ACSHP | Allen County Schools Health Plan

DATE: October 19, 2026

TO: Benefit Eligible Employees of the ACSHP

FROM: Apollo Career Center, a member of the ACSHP

RE: **IMPORTANT** – Annual Open Enrollment Information
Effective Date of Coverage: January 1, 2027

The **ANNUAL OPEN ENROLLMENT** for health, prescription drug, dental, vision, and voluntary life insurance will be from **November 2, 2026 through November 12, 2026** with coverage effective January 1, 2027. Unless you have an IRS qualified life event, this is the only time an employee can (1) change coverage, (2) add or enroll in coverage, or (3) add or remove an eligible dependent or (4) terminate any type of coverage.

For a list of IRS qualified events, check out the ACSHP website at Allen County Schools Health Plan Benefits Portal

************Your benefit elections MUST be completed on-line************

ACSHP uses the **PlanSource** on-line enrollment system. Keep reading for details!

But first, January 1, 2027 - Brings a few Changes

MDHP Medical Plan Changes:
Beginning January 1, 2027, after you meet the deductible, the MDHP plan will pay 50% of eligible non-network office visit costs, and you will be responsible for the remaining 50%. These changes are represented below in RED.

Benefit	MDHP 1/1/26		MDHP Proposed 1/1/27	
	Network	Non-Network	Network	Non-Network
Office Visit – PCP (Illness/Injury)	$25 copay, then 100%.		$25 copay, then 100%.	50% after deductible
On Demand Virtual Telehealth w/PCP	$25 copay, then 100%.		$25 copay, then 100%.	50% after deductible
Specialist Office Visit	$50 copay, then 100%.		$50 copay, then 100%.	50% after deductible
On Demand Virtual Telehealth w/Specialist	$50 copay, then 100%.		$25 copay, then 100%.	50% after deductible
Urgent Care Visit	$60 copay, then 100%.		$60 copay, then 100%.	50% after deductible
Therapy (Physical, Occupational)	$25 copay, then 100%.		$25 copay, then 100%.	50% after deductible
Chiropractic Services	$25 copay, then 100%.		$25 copay, then 100%.	50% after deductible

HDHP Medical Network & Non-Network Deductibles Changes
To comply with IRS Regulations, the HDHP network and non-network deductibles have increased. The coinsurance limit was reduced accordingly to ensure the Maximum Out-of-Pocket limit remains unchanged. These changes are represented below in RED.

HDHP Plan Changes	1/1/26 - 12/31/26				1/1/27 - 12/31/27			
	Network		Non-Network		Network		Non-Network	
	Single	Family	Single	Family	Single	Family	Single	Family
Deductible	$3,400	$6,800	$6,800	$13,600	$3,500	$7,000	$7,000	$14,000
Coinsurance Maximum	$2,500	$5,000	$5,000	$10,000	$2,400	$4,800	$4,800	$9,600
Out-of-Pocket Maximum	$5,900	$11,800	$11,800	$23,600	$5,900	$11,800	$11,800	$23,600

MMO will reissue new Medical ID cards for those enrolled in the MDHP or HDHP plan.

PLEASE USE THE ATTACHED TOOLS FLYER TO FIND WAYS TO HELP IMPROVE HEALTH AND REDUCE COSTS!

Enrolling for the 2027 Plan Year

The online open enrollment process will be an *ACTIVE* enrollment.

What does this mean for you?

- **Action Required:** You **MUST** log on to the PlanSource system and confirm your elections.
- **Life Insurance Elections:**
  - Your Basic Life/AD&D and Voluntary Life, Voluntary Spouse and Voluntary Child elections will copy over for 2027.
  - Be sure to review the voluntary rates. Note, since the rates are age banded, they may increase if you move to the next age band.
- **Medical, Dental and Vision Plans:**
  - You will need actively enroll in the Medical, Dental or Vision plans through the system.
  - If you do not actively enroll or decline coverage for these benefits during the open enrollment period, these benefits will automatically be marked as **declined** for the 2027 plan year. NOTE, as shown below, You will be able to see your current medical plan election when enrolling in coverage.

How do I log on to PlanSource?

- Use **Firefox** or **Google Chrome** as your search engine when logging into the benefit enrollment system. Do not use **Internet Explorer**.

- Type https://benefits.plansource.com into your search engine.

- **USERNAME:** This will NOT change. It is the first initial of your first name, then up to six letters of your last name followed by the last four digits of your SSN.

  Examples:
  Employee name: John Smith User Name is: jsmith4157
  Employee name: Susan Schneider User Name is: sschnei3312

- **PASSWORDS:** All passwords have been reset to a default password, which is your birthdate in this format: YYYYMMDD

- **PLEASE NOTE**: If you worked at another ACSHP district previously, your Username will be slightly different. If you need assistance, contact the Treasurer's office.

For further guidance, visit the ACSHP Website at Allen County Schools Health Plan Benefits Portal for the step-by-step instruction guide on how to log into the Plan Source system. The process is easy!

Dependent Audit & Spousal Coordination of Benefits

- **Dependent Children Audit PROCESS:**
  - **Automatic Agreement Generation:**
    If you have a dependent listed in PlanSource, the **Dependent Verification Acknowledgement Agreement** will automatically generate. This Agreement explains dependent eligibility for the Medical, Dental and Vision benefits, and lists the required documentation to confirm dependent eligibility.

  - **Document Submission Deadline:**
    The required documents can be uploaded directly into PlanSource. If you do not upload the required information before **January 31, 2027**, your dependents will be **removed from the plan effective January 31, 2027.**

  - **Previously Submitted Documentation:**
    If you have already provided documentation on your dependent children in the past, you will NOT need to complete it again.

- **Spousal Coordination of Benefits (COB) Certification PROCESS:**
  - **Spousal COB Survey**
    You must complete the Spousal COB survey if you have a spouse included as a dependent. Based on your response, you may be required to have your spouse's employer complete the **Spousal COB Certification form**.
  - **OPERS Coverage:**
    If your spouse is currently covered through OPERS, you will have the option of enrolling your spouse onto the ACSHP plan as primary. However, please note:
    - This may affect your spouse's ability to receive HRA funds from OPERS.
    - Any and all tax ramifications are your responsibility. Please ensure you fully understand your options before making a decision.
  - **Exemptions from the Spousal COB Certification Form:**
    The **Spousal COB Certification form** will **NOT** be required if any of the following situations apply to your spouse:
    - **Does Not Apply:** I am not covering a spouse
    - **Primary:** My spouse is not employed
    - **Primary:** My spouse is retired and eligible for Medicare
    - **Primary:** My spouse is self-employed and does not offer Medical/Rx coverage to his/her employees
    - **Primary:** My spouse is also employed by one of the following Allen County School Districts (Allen County ESC, Allen East, Apollo, Bath, Bluffton, Delphos, Elida, Lima, Perry, Shawnee, Spencerville, West Central)
    - **Secondary:** My spouse is currently enrolled in his/her Employer's or Retiree Medical/Rx group coverage and will be covered as secondary under the ACSHP medical plan
  - **COB Status TBD:**
    If your response includes, **"COB Status TBD,"** the **Spousal COB Certification Acknowledgement page** will generate. This page explains the Spousal COB requirements for spouses who are eligible for coverage from their own employer or retirement plan. **You will be required to upload a Spousal COB Recertification form in PlanSource.**
  - **Document Submission Deadline:**
    If required, you will need to upload the completed **Spousal COB Certification form** in PlanSource **by January 31, 2027**. Failure to provide the required information will result in your spouse's coverage being **terminated effective January 31, 2027.**

For further guidance, visit the ACSHP Website at Allen County Schools Health Plan Benefits Portal and click on the Life Events tab!

Voluntary Life Insurance

- You may add or increase your Voluntary Life Insurance amount during open enrollment.
- Some changes require **Evidence of Insurability (EOI)** and will not become effective until approved by Dearborn Insurance Company.
- Currently enrolled employees and dependents may increase their Voluntary Life amount up to $10,000 without the Evidence of Insurability requirement.
    - Guarantee Issue Maximums still apply:
        - Employee: 5x the employee's salary or $300,000 employee *whichever is less*
        - Spouse: $50,000

All of the rules are outlined in PlanSource.

If EOI is required, you can complete the EOI while enrolling in PlanSource, or click on this Dearborn EOI Link . When completing the EOI application, you will need to provide the following information for the applicant:

- Employee DOB and SSN will need to be provided once you click on the EOI link for security validation
- Applicant current height and weight
- Applicant treatment history
- Applicant medication(s) for any health conditions(s)
- Applicant name and address of any physician, hospital or practitioner that provided medical care, consultation or treatment

The deadline to complete the EOI application is December 18, 2026.

IMPORTANT DATES TO REMEMBER

Employee Open Labs will be held on November 3 and 10, 2026 Time: 2:30-3:15 pm
Location: CIS Lab Room 237
Open Enrollment Period: November 2, 2026 through November 12, 2026

DEADLINE TO COMPLETE ON-LINE ENROLLMENT

All eligible employees MUST complete their benefit elections via the PlanSource Self-Service Enrollment system no later than November 12, 2026. The system will close on this date. Failure to do so may result in loss or delay of coverage effective January 1, 2027.

Health Insurance Website

The ACSHP Website Allen County Schools Health Plan Benefits Portal has lots of great information, including:

- **Open Enrollment Section *(located on the home page)* that includes:**
  - **PlanSource Enrollment Guide**
  - **Benefit Summaries & SBCs** for all of the plans offered
  - **Videos** outlining **PPO vs. HDHP** and **Health Savings Account (HSA) vs. FSA** rules and regulations
  - Your **ComPsych® Guidance Resources®** which provides Employee Assistance for all employees for anything that stresses you!
  - **Information on Teladoc which is 24/7/365** access to U.S. board certified doctors through the convenience of phone or video consults, saving you time & money.
  - **Required Annual Notices**
  - **Customer Service Numbers** and links
  - **Spousal Coordination of Benefits** Rules and Forms
  - How to **log on to Medical Mutual of Ohio's** website to find network providers, check the status of a claim, review EOBs, view your member ID card, utilize SmartShopper or contact customer service.
  - **How to find a dentist or vision provider**
  - Information about our **Wellness Program**
  - And so much more!

SmartShopper

How to Use SmartShopper® and Earn Cash Rewards

SmartShopper® Makes It Easy to Save on Medical Procedures. Medical procedure costs can vary widely depending on the location. With SmartShopper®, you can compare in-network providers and earn a cash reward when you choose a cost-effective option.
Here's how to get started:

Browse Locations Online

1. Visit MMO SmartShopper
2. Log in or create an account
3. Compare in-network locations, costs, and reward amounts

Call a Care Concierge

Dial **877-292-1541** for personalized support. A Care Concierge can help you:

- Find a location
- Compare costs
- Confirm reward amounts
- Schedule your appointment

Availability:
Monday–Thursday: 8 a.m. – 8 p.m. ET
Friday: 8 a.m. – 6 p.m. ET (Summer Fridays close at 3 p.m. ET)

Learn More
To review the SmartShopper flyer and see the list of elective services eligible for rewards:

- Visit the ACSHP Website Allen County Schools Health Plan Benefits Portal at the Allen County Schools Health Plan Benefits Portal.
- Click on the Benefits tab.
- Select the SmartShopper Section.

FEDlogic - A Resource for You and Your Household

Don't forget about this service that is available to you and your household members! This service is unlimited, **confidential, and free** and **it applies to ALL employees** whether or not you are eligible for benefits.

What is FEDlogic?
FEDlogic is an independent educational resource staffed by experts in all fields of benefits, beyond what is offered through our District. Their team is here to help you navigate complex benefit options and make informed decisions.

Why Contact a FEDlogic Expert?
Here are some situations where FEDlogic can provide valuable guidance:

- **Medicare Assistance:** You're approaching or have reached age 65 and need unbiased help understanding Medicare and the options available to you.
- **Retirement Planning:** You're 62 or older and want to maximize your retirement benefits now or plan for the future.
- **Major Health Diagnoses:** You or a family member have been diagnosed with a major ailment (e.g., cancer, ESRD, ALS).
- **Family Support:** You have a child born prematurely or a family member with a disability.
- **Survivor Benefits:** You've lost a spouse and need help understanding survivors' benefits.
- **Health Coverage Challenges**: You are unable to work or have lost access to affordable health coverage.
- **Dependent Coverage:** Your dependent child is no longer eligible for the medical plan due to turning age 26.

How FEDlogic Can Help?
FEDlogic provides the information you need to make informed decisions about your benefit options. Their experts have years of experience working for the Social Security Administration and understand these policies inside and out.

Without proper education and advocacy, many individuals miss out on benefits they are entitled to. FEDlogic ensures you don't leave any benefits on the table.

What Makes FEDlogic Unique?
They do not sell, endorse, or promote any products or services.
They provide unbiased education and practical guidance to support families during life changes.

Accessing FEDlogic Resources

- Visit the FEDlogic website FEDLogic or scan the QR code below.
- Use the employee access code provided below to log in.
- Explore recorded audio series and monthly webinars for additional support.

ACSHP | Allen County Schools Health Plan

EMPLOYEE ACCESS CODE: alcs25

SCAN THE QR CODE TO ACCESS YOUR RESOURCES

Contact FEDlogic at 877-837-4196 or via email at services@fedlogicgroup.com to schedule a phone consultation at your convenience with one of their experts.

You can also view this valuable information at the ACSHP Benefits Website: ACSHP Benefits Website - FEDlogic

Allen County Schools Health Plan
Funding Rates effective January 1, 2027
Worksheet

	2027 Rates	Board	Employee	Pay Periods
MDHP		**85%**	**15%**	**24**
Single	$965.34	$820.54	$144.80	$72.40
Family	$2,392.74	$2,033.83	$358.91	$179.46
HDHP		**85%**	**15%**	**24**
Single	$858.34	$729.59	$128.75	$64.38
Family	$2,128.50	$1,809.22	$319.28	$159.64
Dental		**85%**	**15%**	**24**
Composite	$102.64	$87.24	$15.40	$7.70
Vision		**0%**	**100%**	**24**
Employee Only	$6.78	$0.00	$6.78	$3.39
EE + Spouse	$12.90	$0.00	$12.90	$6.45
EE + Children	$13.56	$0.00	$13.56	$6.78
EE + Family	$19.94	$0.00	$19.94	$9.97

Apollo Opt-Out Stipends

Medical (25% of Board Share MDHP)	
Per Month	$205.14
Total for Calendar Year	$2,461.68
Dental (25% of Board Share)	
Per Month	$21.81
Total for Calendar Year	$261.72
Both Medical & Dental	
Per Month	$226.95
Total for Calendar Year	$2,723.40

Allen County Schools Health Plan
Passive PPO Dental Summary of Benefits
SDC Network

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	Age 26; removal End of Month	
Benefit Period Maximum (per member)	$2,500	
Benefit Period Deductible (per member)	$25 Single / $50 Family	
Class I - Preventive & Diagnostic	100% (no deductible)	100% (no deductible)
Class II - Basic Restorative/Essential	85% after deductible	85% after deductible
Class III - Major Restorative/Complex	80% after deductible	80% after deductible
Class IV - Orthodontia	60% (no deductible)	60% (no deductible)
Orthodontic Lifetime Maximum (per member)	$1,000	

Under the Passive PPO plan, you may choose at the time of service a SDC participating dentist or any nonparticipating dentist. With the PPO plan, savings are possible because the participating dentists have agreed to provide care for covered services at negotiated rates and cannot balance bill. Nonparticipating benefits are based on the usual and customary fees in the geographic areas in which the expenses are incurred.

For a current listing of participating dental providers from the SDC Network by using the network search on MMO's website:

SDC Network

This summary of benefits is intended to be a brief outline of coverage. The contract and/or certificate will contain the complete listing of covered services. In the event of a conflict between the contract and this summary, the group contract will prevail.

Allen Cty Health Plan

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are for in-network providers only

Take a sneak peek before enrolling

- You're on the INSIGHT Network
- For a complete list of **in-network** providers near you, use our **Enhanced** Provider Locator on www.eyemed.com or call **1-866-804-0982**.
- For Lasik providers, call 1-877-5LASER6.

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$10 Co-pay	Up to $40
Retinal Imaging	Up to $39	N/A
Frames	$0 Co-pay; $150 allowance; 80% of charge over $150	Up to $105
Standard Plastic Lenses		
Single Vision	$15 Co-pay	Up to $30
Bifocal	$15 Co-pay	Up to $50
Trifocal	$15 Co-pay	Up to $70
Standard Progressive Lens	$80 Co-pay	Up to $50
Premium Progressive Lens[Δ]	$100 Co-pay - $125 Co-pay	
Tier 1	$100 Co-pay	Up to $50
Tier 2	$110 Co-pay	Up to $50
Tier 3	$125 Co-pay	Up to $50
Tier 4	$80 Co-pay, 80% of charge less $120 Allowance	Up to $50
Lenticular	$15 Co-pay	Up to $70
Lens Options (paid by the member and added to the base price of the lens)		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Polycarbonate - Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Premium Anti-Reflective Coating[Δ]	$57 - $68	N/A
Tier 1	$57	N/A
Tier 2	$68	N/A
Tier 3	80% of charge	N/A
Photochromic/Transitions	$75	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lens Fit and Follow-Up (Contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to $55	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail	N/A
Contact Lenses		
Conventional	$0 Co-pay; $150 allowance; 15% off retail price over $150	Up to $150
Disposable	$0 Co-pay; $150 allowance; plus balance over $150	Up to $150
Medically Necessary	$0 Co-pay, Paid-in-Full	Up to $210
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	

ΔPremium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level . All providers are not required to carry all brands at all levels. Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment. Safety eyewear; 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. The Certificate of Insurance is on file with your employer. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

What's in it for me?

Options. It's simple really. We're dedicated to helping you see clearly – and that's why we've built a network that gives you lots of choices and flexibility. You can choose from thousands of independent and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy-to-use and help you access the care you need. Welcome to EyeMed.

Benefits Snapshot	With EyeMed	Out-of-Network Reimbursement
Exam with dilation as necessary (Once every 12 months)	$10 Co-pay	Up to $40
Frames (Once every 24 months)	$0 Co-pay; $150 allowance; 80% of charge over $150	Up to $105
Single Vision Lenses (Once every 12 months) Or **Contacts** (Once every 12 months)	$15 Co-pay $0 Co-pay; $150 allowance; plus balance over $150	Up to $30 Up to $150

And now it's time for the breakdown . . .

Here's an example of what you might pay for a pair of glasses with us vs. what you'd pay without vision coverage. So, let's say you get an eye exam and choose a frame that costs $163 with single vision lenses that have UV and scratch protection. Now let's see the difference...

84%
SAVINGS with us*

With EyeMed	Without Insurance**
Exam $10 Co-pay	Exam $106
Frame $163 -$150 allowance $13 -$2.60 (20% discount off balance) $10.40	Frame $163
Lens $15 Co-pay $15 UV treatment add-on +$15 Scratch coating add-on $45	Lens $78 $23 UV treatment add-on +$25 Scratch coating add-on $126
Total $65.40	Total $395



Download the EyeMed Members App

It's the easy way to view your ID card, see benefit details and find a provider near you.

EyeMed | INDEPENDENT PROVIDER NETWORK + LensCrafters | Pearle Vision | Target Optical | Sears Optical | JCPenney | optical

*This is a snapshot of your benefits. Actual savings will depend on provider, frame and lens selections. **Based on industry averages

Allen County Schools Health Plan January 1, 2027 Benefit Plans

	Effective January 1, 2026				Proposed Effective January 1, 2027			
	MDHP		HDHP		MDHP		HDHP	
	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network
Benefit Period	Calendar Year		Calendar Year		Calendar Year		Calendar Year	
Dependent Age	26 - Removal End of Month		26 - Removal End of Month		26 - Removal End of Month		26 - Removal End of Month	
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
Benefit Period Deductible – Single/Family	$1,250 / $2,500	$2,500 / $5,000	$3,400 / $6,800	$6,800 / $13,600	$1,250 / $2,500	$2,500 / $5,000	$3,500 / 7,000	$7,000 / $14,000
	Embedded Deductible - On a family contract, no one family member will pay more than a single contract.		Embedded Deductible - On a family contract, no one family member will pay more than a single contract.		Embedded Deductible - On a family contract, no one family member will pay more than a single contract.		Embedded Deductible - On a family contract, no one family member will pay more than a single contract.	
Coinsurance - Amount Plan pays after Deductible or Copays, unless	75%	50%	90%	60%	75%	50%	90%	60%
Coinsurance Maximum – Single/Family	$3,000 / $6,000	$6,000 / $12,000	$2,500 / $5,000	$5,000 / $10,000	$3,000 / $6,000	$6,000 / $12,000	$2,400 / $4,800	$4,800 / $9,600
	Embedded Coinsurance - On a family contract, no one family member will pay more than a single contract.		Embedded Coinsurance - On a family contract, no one family member will pay more than a single contract.		Embedded Coinsurance - On a family contract, no one family member will pay more than a single contract.		Embedded Coinsurance - On a family contract, no one family member will pay more than a single contract.	
Out-of-Pocket Maximum - Single/Family	$4,250 / $8,500	$8,500 / $17,000	$5,900 / $11,800	$11,800 / $23,600	$4,250 / $8,500	$8,500 / $17,000	$5,900 / $11,800	$11,800 / $23,600
	(Deductible + Coinsurance ONLY) Medical & Rx copays continue to apply to the ACA statutory maximum of $9,200 / $18,400 for 2026 Embedded Out-of-Pocket - On a family contract, no one family member will pay more than a single contract.		(Deductible + Coinsurance + Medical & Rx copays) Embedded Out-of-Pocket. On a family contract, no one family member will pay more than a single contract.		(Deductible + Coinsurance ONLY) Medical & Rx copays continue to apply to the ACA statutory maximum of $12,000 / $24,000 for 2027 Embedded Out-of-Pocket - On a family contract, no one family member will pay more than a single contract.		(Deductible + Coinsurance + Medical & Rx copays) Embedded Out-of-Pocket. On a family contract, no one family member will pay more than a single contract.	
Services with Copays - *flat dollar copays do accumulate toward the Out-of-Pocket Maximum.*								
Office Visit – PCP (Illness/Injury)	$25 copay, then 100%. Includes most services performed during that visit.		90%, after deductible	60%, after deductible	$25 copay, then 100%. Includes most services performed during that visit.	50% after deductible	90%, after deductible	60%, after deductible
Office Visit -Specialist (Illness/Injury)	$50 copay, then 100%. Includes most services performed during that visit.		90%, after deductible	60%, after deductible	$50 copay, then 100%. Includes most services performed during that visit.	50% after deductible	90%, after deductible	60%, after deductible
Well Child Care Services (Under age 21)	100% No deductible	50% after deductible	100% No deductible	60%, after deductible	100% No deductible	50% after deductible	100% No deductible	60%, after deductible
Urgent Care Office Visit	$60 copay, then 100%. Includes most services performed during that visit.		90%, after deductible	60%, after deductible	$60 copay, then 100%. Includes most services performed during that visit.	50% after deductible	90%, after deductible	60%, after deductible
Emergency use of an Emergency Room	$150 copay, then 75% after deductible. Copay Waived if Admitted		Deductible, $85 copay, then 90% Copay Waived if Admitted		$150 copay, then 75% after deductible. Copay Waived if Admitted		Deductible, $85 copay, then 90% Copay Waived if Admitted	
Non-Emergency use of an Emergency Room	$300 copay, then 75% after deductible.		Deductible, $200 copay, then 90%		$300 copay, then 75% after deductible.		Deductible, $200 copay, then 90%	
Inpatient and Outpatient Facility								
Semi-Private Room and Board	75% after deductible	50% after deductible	90% after deductible	60% after deductible	75% after deductible	50% after deductible	90% after deductible	60% after deductible
Diagnostic Services (Labs, Imaging, X-rays and Testing)	75% after deductible	50% after deductible	90% after deductible	60% after deductible	75% after deductible	50% after deductible	90% after deductible	60% after deductible
Medical & Surgical Services (Anesthesia, Assist. Surgeon, Pathology, Theraputic Injections & Misc. Medical Services)	75% after deductible	50% after deductible	90% after deductible	60% after deductible	75% after deductible	50% after deductible	90% after deductible	60% after deductible
Surgical Services (Professional, Diagnostic Endoscopic Services)	$25 copay then 75% Physician Office; 75% after deductible elsewhere	$25 copay then 50% Physician Office; 50% after deductible elsewhere	90% after deductible	60% after deductible	$25 copay then 75% Physician Office; 75% after deductible elsewhere	$25 copay then 50% Physician Office; 50% after deductible elsewhere	90% after deductible	60% after deductible

	Effective January 1, 2026				Proposed Effective January 1, 2027			
	MDHP		HDHP		MDHP		HDHP	
	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network
Drug & Biologicals	75% after deductible	50% after deductible	90% after deductible	60% after deductible	75% after deductible	50% after deductible	90% after deductible	60% after deductible
Durable Medical Equipment	75% after deductible	50% after deductible	90% after deductible	60% after deductible	75% after deductible	50% after deductible	90% after deductible	60% after deductible
Medical Supplies	75% after deductible	50% after deductible	90% after deductible	60% after deductible	75% after deductible	50% after deductible	90% after deductible	60% after deductible
Therapy (Physical, Occupational)	$25 copay, then 100%.		90% after deductible	60% after deductible	$25 copay, then 100%.	**50% after deductible**	90% after deductible	60% after deductible
Therapy (Speech)	75% after deductible	50% after deductible	90% after deductible	60% after deductible	75% after deductible	50% after deductible	90% after deductible	60% after deductible
Additional Services								
Ambulance	75% after deductible	50% after deductible	90% after deductible	60% after deductible	75% after deductible	50% after deductible	90% after deductible	60% after deductible
Chiropractic Services	$25 copay, then 100%. (26 visits per benefit period)		90% after deductible (26 visits per benefit period)	60% after deductible	$25 copay, then 100%. (26 visits per benefit period)	**50% after deductible**	90% after deductible (26 visits per benefit period)	60% after deductible
Durable Medical Equipment	75% after deductible	50% after deductible	90% after deductible	60% after deductible	75% after deductible	50% after deductible	90% after deductible	60% after deductible
Home Healthcare	75% after deductible	50% after deductible	90% after deductible	60% after deductible	75% after deductible	50% after deductible	90% after deductible	60% after deductible
Hospice	75% after deductible	50% after deductible	90% after deductible	60% after deductible	75% after deductible	50% after deductible	90% after deductible	60% after deductible
Outpatient Allergy Testing	75% after deductible	50% after deductible	90% after deductible	60% after deductible	75% after deductible	50% after deductible	90% after deductible	60% after deductible
Outpatient Allergy Treatment	75% after deductible	50% after deductible	90% after deductible	60% after deductible	75% after deductible	50% after deductible	90% after deductible	60% after deductible
Mental Health and Substance Abuse - Federal Mental Health Parity								
Inpatient Mental Health & Substance Abuse Services	Benefits paid based on corresponding medical benefits		Benefits paid based on corresponding medical benefits		Benefits paid based on corresponding medical benefits		Benefits paid based on corresponding medical benefits	
Outpatient Mental Health & Substance Abuse Services								
Bariatric Surgery	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Lasik	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Prescription Drugs Express Scripts National Preferred Formulary Network	**Copays apply after separate retail calendar year deductible ($100/person, $200/two people, $300 family) has been met.** **Retail - 30 day supply** Generic: $20 copay Formulary Brand: $45 copay Non-Formulary Brand: $90 copay **Mail Order - 90 day supply** Generic: $40 copay Formulary Brand: $90 copay Non-Formulary Brand: $180 copay **Specialty Drugs - limited to a 30 day supply** 20% with a maximum of $125 **Must obtain thru ESI Specialty Pharmacy**		**Copays apply after the calendar year deductible has been met.** **Retail - 30 day supply** Generic: $20 copay Formulary Brand: $45 copay Non-Formulary Brand: $90 copay **Mail Order - 90 day supply** Generic: $40 copay Formulary Brand: $90 copay Non-Formulary Brand: $180 copay **Specialty Drugs - limited to a 30 day supply** 20% with a maximum of $125 **Must obtain thru ESI Specialty Pharmacy**		**Copays apply after separate retail calendar year deductible ($100/person, $200/two people, $300 family) has been met.** **Retail - 30 day supply** Generic: $20 copay Formulary Brand: $45 copay Non-Formulary Brand: $90 copay **Mail Order - 90 day supply** Generic: $40 copay Formulary Brand: $90 copay Non-Formulary Brand: $180 copay **Specialty Drugs - limited to a 30 day supply** 20% with a maximum of $125 **Must obtain thru ESI Specialty Pharmacy**		**Copays apply after the calendar year deductible has been met.** **Retail - 30 day supply** Generic: $20 copay Formulary Brand: $45 copay Non-Formulary Brand: $90 copay **Mail Order - 90 day supply** Generic: $40 copay Formulary Brand: $90 copay Non-Formulary Brand: $180 copay **Specialty Drugs - limited to a 30 day supply** 20% with a maximum of $125 **Must obtain thru ESI Specialty Pharmacy**	

This analysis is for illustrative purposes only, and is not a proposal for coverage or a guarantee of future expenses, claims costs, managed care savings, etc. There are many variables that can affect future health care costs including utilization patterns, catastrophic claims, changes in plan design, health care trend increases, etc. This analysis does not amend, extend, or alter the coverage provided by the actual insurance policies and contracts. See your policy or contact us for specific information or further details in this regard.

Allen County Schools Health Plan Benefits Website

Our website gives you 24/7 access to so much information:

Home Tab

- Open Enrollment Information
- PlanSource Link & Guide
- Carrier Contact Information

Benefits Tab

Separate Sections for:

- Medical
- Teladoc
- Dental
- Vision
- EAP
- Life
- FSA

Provider Sites

Quick links to all carrier sites to find a provider

Miscellaneous Tab

- Cost Savings Tools
- Personal & Financial Calculators
- Legislation Notices

Wellbeing & Engagement Tab

Overview of Wellbeing Program with Julie Moore along with resources

Life Events Tab

Describes the different qualifying life events which would allow you to make mid-year changes outside of the annual enrollment

WebMD Tab

Includes current articles about health and wellbeing

Discount Programs Tab

Includes access to various discount programs available to you.

Click on link to access the website:
Allen County Schools Health Plan Benefits Portal

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Don't forget to Use these Tools!

We know that the healthcare system can be difficult to navigate which is why we provide our members with tools to assist!

MMO Customer Care

MMO service team to answer any questions or concerns with your Medical or Prescription Drug coverage.

Call 1.800.382.5729
Mon. - Thurs. - 7:30 am - 7:30 pm
Fri. - 7:30 am - 6:00 pm
Sat. - 9:00 am - 1:00 pm

Nurseline

AFTER HOURS - If you are unsure whether you should go to the emergency room, urgent care or be directed to another source of care, Nurseline will assist!

Call 1.888.912.0636
Available 24 hours a day,
7 days a week

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Sword Health

Back, joint or muscle pain?
Or did you recently have hip, knee, shoulder surgery and need a bit more physical therapy in the comfort of your home?
This program provides you with a certified physical therapist virtually that has proven to ease pain and help recover from surgery.

Enroll to get started:
https://join.swordhealth.com/medmutual/register
For Questions: **1.888.246.0476**
Mon. – Fri. 9am – 6pm

ComPsych

All benefit eligible employees are automatically enrolled in the EAP program by Compsych. This includes 6 free counseling sessions available for each unrelated issue in a 12 month period. They help with anything that brings stress into your life!

- ❑ Adoption
- ❑ Advanced Directives
- ❑ Bankruptcy
- ❑ Divorce or Separation
- ❑ Family Law
- ❑ General Financial
- ❑ Income Tax
- ❑ Medicaid, Medicare, SSDI

Here when you need us.
Call: 833-787-7774
TTY: 800.697.0353
Online: guidanceresources.com
App: GuidanceNow℠
Web ID: ACSHP

SmartShopper

Cash for Smart Decisions!
The next time you need a non-emergent procedure, contact SmartShopper first! Either by phone or online, you describe the service you need and SmartShopper will provide cost and quality information for providers in the network!.
Completely voluntary!
You can select one of the providers they recommend and receive a CASH award or use a different provider.

Concierge Team: 1.877.292.1541
Mon. – Thurs. 8am – 8pm
Fri. – 8am – 6pm
Or log on at ADD WEBSITE

Do Your Part to stay healthy and keep costs down by joining the Wellness Program and using all of the tools available to you! We are all in this together!

You can earn rewards by participating in the wellness program!

Allen County Schools Health Plan

Allen County Schools Health Plan Benefits Portal

YES! All the benefit plan information, customer service numbers, links to carrier websites, information about the **wellness program** along with all these tools are accessible 24 hours a day, 7 days a week for your use!

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 800-332-0741. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other underlined terms see the Glossary. You can view the Glossary at MedMutual.com/SBC or call 800-332-0741 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,250**/single,**$2,500**/family Network **$2,500**/single,**$5,000**/family Non-Network	Generally, you must pay all of the costs from providers up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible.**
Are there services covered before you meet your deductible?	**Yes. Certain preventive care and all services with copayments are covered and paid by the plan before you meet your deductible.**	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, $100/single,$300/family network for prescription drugs	You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services..
What is the out-of-pocket limit for this plan?	**Coinsurance Limit:** **$3,000**/single,**$6,000**/family Network **$6,000**/single,**$12,000**/family Non-Network **Out-of-pocket Limit:** **$12,000**/single,**$24,000**/family Network **Unlimited**/single,**Unlimited**/family Non-Network	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Certain **specialty drugs**, **premiums**, balance-billed charges and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**

Will you pay less if you use a network provider?	Yes, See MedMutual.com/SBC or call 800-332-0741 for a list of participating providers.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**). Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No	You can see the **specialist** you choose without a **referral.**



All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. Services with **copayments** are covered before you meet your **deductible**, unless otherwise specified.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	50% coinsurance	None
	Specialist visit	$50 copay/visit	50% coinsurance	None
	Preventive care/ screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray)	25% coinsurance	50% coinsurance	None
	Diagnostic test (blood work)	25% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	None

[For more information about limitations and exceptions, see the plan or policy document at MedMutual.com/SBC.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at MedMutual.com/SBC	Generic copay - retail Tier 1	$20	See Plan Documents for Details	Covers up to a 30-day supply.
	Generic copay - home delivery Tier 1	$40	See Plan Documents for Details	Covers up to a 90-day supply.
	Preferred brand copay - retail Tier 2	$45	See Plan Documents for Details	Covers up to a 30-day supply.
	Preferred brand copay - home delivery Tier 2	$90	See Plan Documents for Details	Covers up to a 90-day supply.
	Non-preferred brand copay - retail Tier 3	$90	See Plan Documents for Details	Covers up to a 30-day supply.
	Non-preferred brand copay - home delivery Tier 3	$180	See Plan Documents for Details	Covers up to a 90-day supply.
	Specialty drugs	20% up to $125 max. of any available manufacturer-funded copay assistance	See Plan Documents for Details	Covers up to a 30 day supply. Certain specialty drugs are considered non-essential health benefits and therefore do not apply to the out-of-pocket maximum. They will also be subject to higher cost-share.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees (Outpatient)	$25 copay/visit, 25% coinsurance at Physician; 25% coinsurance for all other places after deductible	$25 copay/visit, 50% coinsurance at Physician; 50% coinsurance for all other places after deductible	None
If you need immediate medical attention	Emergency room care	$150 copay/visit, **deductible**, 25% **coinsurance**		None
	Emergency medical transportation	25% coinsurance	50% coinsurance	None
	Urgent care	$60 copay/visit	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	None
	Physician/ surgeon fee (inpatient)	25% coinsurance	50% coinsurance	None

[For more information about limitations and exceptions, see the plan or policy document at MedMutual.com/SBC.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Benefits paid based on corresponding medical benefits		None
	Inpatient services	Benefits paid based on corresponding medical benefits		None
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, copay, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	None
	Rehabilitation services (Physical Therapy)	$25 copay/visit	50% coinsurance	None
	Habilitation services (Occupational Therapy)	$25 copay/visit	50% coinsurance	None
	Habilitation services (Speech Therapy)	25% coinsurance	50% coinsurance	None
	Skilled nursing care	25% coinsurance	50% coinsurance	None
	Durable medical equipment	25% coinsurance	50% coinsurance	None
	Hospice services	25% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	None
	Children's glasses	Not Covered		Excluded Service
	Children's dental check-up	Not Covered		Excluded Service

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Children's dental check-up
- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care
- Hearing Aids
- Private-Duty Nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends.The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact your plan at 800-332-0741.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

----------*To see examples of how this plan might cover costs for sample medical situations, see the next section*----------

The coverage example numbers assume that the patient does not use an HRA or FSA. If you participate in an HRA or FSA and use it to pay for out-of-pocket expenses, then your costs may be lower.

[For more information about limitations and exceptions, see the plan or policy document at MedMutual.com/SBC.]

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$1,250**
- **Specialist copay** **$50**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$1,300
Copayments	$10
Coinsurance	$2,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,170**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$1,250**
- **Specialist copay** **$50**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$100
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$1,250**
- **Specialist copay** **$50**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,300
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 800-332-0741.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.

[For more information about limitations and exceptions, see the plan or policy document at MedMutual.com/SBC.]

Notice of Availability of Language Assistance and Auxiliary Aids and Services

MEDICAL MUTUAL®

English
ATTENTION: If you speak [language], free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-382-5729 (TTY: 711) or speak to your provider.

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-382-5729 (TTY: 711) o hable con su proveedor.

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ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-382-5729 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Italian
ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' 1-800-382-5729 (TTY: 711) o parla con il tuo fornitore.

Russian
ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-382-5729 (TTY: 1-711) или обратитесь к своему поставщику услуг.

French
ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-382-5729 (TTY: 711) ou parlez à votre fournisseur.

Chinese
注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-982-3117（文本电话：711）或咨询您的服务提供商。

Vietnamese
LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-382-5729 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn."

Arabic
العربيةتنبيه: إذا كنت تتحدث اللغة العربية، فسوف تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-382-5729 (TTY: 711)

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주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-382-5729 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Cushite/Oromo
HUBACHIISA: Yoo Afaan Oromoo dubbattu ta'e, tajaajiloonni gargaarsa afaanii bilisaa isiniif ni argamu. Deeggarsi dabalataa fi tajaajilootni mijaa'oo ta'an odeeffannoo bifa dhaqqabamaa ta'een kennuuf gargaaranis kaffaltii malee ni argamu. Gara 1-800-382-5729 (TTY: 711) tti bilbilaa ykn dhiyeessaa keessan haasofsiisaa.

Tagalog
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-382-5729 (TTY: 711) o makipag-usap sa iyong provider.

Romanian
ATENȚIE: Dacă vorbiți Română, aveți la dispoziție servicii de asistență lingvistică gratuite. De asemenea, sunt disponibile gratuit materiale și servicii auxiliare adecvate pentru furnizarea de informații în formate accesibile. Sunați la 1-800-382-5729 (TTY: 711) sau contactați-vă furnizorul.

Japanese
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Dutch

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Pennsylvania Dutch

WICHDICH: Wann du Deitsch schwetzscht un hoscht Druwwel fer Englisch verschtehe, kenne mer epper beigriege fer dich helfe unni as es dich ennich eppes koschte zeelt. Mir kenne dich helfe aa wann du Druwwel hoscht fer heere odder sehne. Mir kenne Schtofft lauder mache odder iesier fer lese un sell koscht dich aa nix. Ruf 1-800-382-5729 (TTY: 711) uff odder schwetz mit dei Provider.

Ukrainian

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Navajo

SHOOH: Diné bee y1ni[ti'gogo, saad bee an1'awo' bee 1ka'an7da'awo'7t'11 jiik'eh n1 h0l=. Bee ahi[hane'go bee nida'anish7 t'11 1kodaat'4h7g77 d00 bee 1ka'an7da'wo'7 1ko bee baa hane'7 bee hadadilyaa bich'8' ahoot'i'7g77 47 t'11 jiik'eh h0l=. Kohj8' 1-800-382-5729 (TTY: 711) hod7ilnih doodago nika'an1lwo'7 bich'8' hanidziih.

Notice of Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

Medical Mutual of Ohio complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). Medical Mutual of Ohio does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Medical Mutual of Ohio:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator at CivilRightsCoordinator@MedMutual.com.

If you believe that Medical Mutual of Ohio has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

100 American Road
Cleveland, OH 44144

Call: 1-800-382-5729 (TTY: 711)
Email: CivilRightsCoordinator@MedMutual.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, our Civil Rights Coordinator (who is also our Section 1557 Coordinator) is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

- Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html
- This notice is available at Medical Mutual's website: www.MedMutual.com

Questions about your benefits or other inquiries about your health insurance should be directed to Medical Mutual's Customer Care Department at 1-800-382-5729.

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 800-332-0741. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other underlined terms see the Glossary. You can view the Glossary at MedMutual.com/SBC or call 800-332-0741 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$3,500**/single,**$7,000**/family Network **$7,000**/single,**$14,000**/family Non-Network	Generally, you must pay all of the costs from providers up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible.**
Are there services covered before you meet your deductible?	**Yes. Certain preventive care and all services with copayments are covered and paid by the plan before you meet your deductible.**	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**$5,900**/single,**$11,800**/family Network **$11,800**/single,**$23,600**/family Non-Network	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Certain **specialty drugs**, **premiums**, balance-billed charges and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Will you pay less if you use a network provider?	Yes, See MedMutual.com/SBC or call 800-332-0741 for a list of participating providers.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**). Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No	You can see the **specialist** you choose without a **referral.**



All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. Services with **copayments** are covered before you meet your **deductible**, unless otherwise specified.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	40% coinsurance	None
	Specialist visit	10% coinsurance	40% coinsurance	None
	Preventive care/ screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray)	10% coinsurance	40% coinsurance	None
	Diagnostic test (blood work)	10% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	None

[For more information about limitations and exceptions, see the plan or policy document at MedMutual.com/SBC.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at MedMutual.com/SBC	Generic copay - retail Tier 1	$20 after deductible	See Plan Documents for Details	Covers up to a 30-day supply.
	Generic copay - home delivery Tier 1	$40 after deductible	See Plan Documents for Details	Covers up to a 90-day supply.
	Preferred brand copay - retail Tier 2	$45 after deductible	See Plan Documents for Details	Covers up to a 30-day supply.
	Preferred brand copay - home delivery Tier 2	$90 after deductible	See Plan Documents for Details	Covers up to a 90-day supply.
	Non-preferred brand copay - retail Tier 3	$90 after deductible	See Plan Documents for Details	Covers up to a 30-day supply.
	Non-preferred brand copay - home delivery Tier 3	$180 after deductible	See Plan Documents for Details	Covers up to a 90-day supply.
	Specialty drugs	20% up to $125 max. of any available manufacturer-funded copay assistance	See Plan Documents for Details	Covers up to a 30 day supply. Certain specialty drugs are considered non-essential health benefits and therefore do not apply to the out-of-pocket maximum. They will also be subject to higher cost-share.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	None
	Physician/surgeon fees (Outpatient)	10% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	**Deductible**, $85 copay/visit; 10% **coinsurance**		None
	Emergency medical transportation	10% coinsurance	40% coinsurance	None
	Urgent care	10% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	None
	Physician/ surgeon fee (inpatient)	10% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Benefits paid based on corresponding medical benefits		None
	Inpatient services	Benefits paid based on corresponding medical benefits		None

[For more information about limitations and exceptions, see the plan or policy document at MedMutual.com/SBC.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, copay, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	None
	Rehabilitation services (Physical Therapy)	10% coinsurance	40% coinsurance	None
	Habilitation services (Occupational Therapy)	10% coinsurance	40% coinsurance	None
	Habilitation services (Speech Therapy)	10% coinsurance	40% coinsurance	None
	Skilled nursing care	10% coinsurance	40% coinsurance	None
	Durable medical equipment	10% coinsurance	40% coinsurance	None
	Hospice services	10% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance	None
	Children's glasses	Not Covered		Excluded Service
	Children's dental check-up	Not Covered		Excluded Service

[For more information about limitations and exceptions, see the plan or policy document at MedMutual.com/SBC.]

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Children's dental check-up
- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care
- Hearing Aids
- Private-Duty Nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends.The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact your plan at 800-332-0741.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

----------*To see examples of how this plan might cover costs for sample medical situations, see the next section*----------

The coverage example numbers assume that the patient does not use an HRA or FSA. If you participate in an HRA or FSA and use it to pay for out-of-pocket expenses, then your costs may be lower.

[For more information about limitations and exceptions, see the plan or policy document at MedMutual.com/SBC.]

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$3,500**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$10
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,470**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$3,500**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$300
Coinsurance	$10
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,830**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$3,500**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,790**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 800-332-0741.

The plan would be responsible for the other costs of these EXAMPLE covered services.

[For more information about limitations and exceptions, see the plan or policy document at MedMutual.com/SBC.]

Notice of Availability of Language Assistance and Auxiliary Aids and Services

MEDICAL MUTUAL®

English
ATTENTION: If you speak [language], free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-382-5729 (TTY: 711) or speak to your provider.

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-382-5729 (TTY: 711) o hable con su proveedor.

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-382-5729 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Italian
ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' 1-800-382-5729 (TTY: 711) o parla con il tuo fornitore.

Russian
ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-382-5729 (TTY: 1-711) или обратитесь к своему поставщику услуг.

French
ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-382-5729 (TTY: 711) ou parlez à votre fournisseur.

Chinese
注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-982-3117（文本电话：711）或咨询您的服务提供商。

Vietnamese
LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-382-5729 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn."

Arabic
العربيةتنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-382-5729 (TTY: 711)

Korean
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УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-382-5729 (TTY: 711) або зверніться до свого постачальника.

Navajo

SHOOH: Diné bee y1ni[ti'gogo, saad bee an1'awo' bee 1ka'an7da'awo'7t'11 jiik'eh n1 h0l=. Bee ahi[hane'go bee nida'anish7 t'11 1kodaat'4h7g77 d00 bee 1ka'an7da'wo'7 1ko bee baa hane'7 bee hadadilyaa bich'8' ahoot'i'7g77 47 t'11 jiik'eh h0l=. Kohj8' 1-800-382-5729 (TTY: 711) hod7ilnih doodago nika'an1lwo'7 bich'8' hanidziih.

Notice of Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

Medical Mutual of Ohio complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). Medical Mutual of Ohio does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Medical Mutual of Ohio:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator at CivilRightsCoordinator@MedMutual.com.

If you believe that Medical Mutual of Ohio has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

100 American Road
Cleveland, OH 44144

Call: 1-800-382-5729 (TTY: 711)
Email: CivilRightsCoordinator@MedMutual.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, our Civil Rights Coordinator (who is also our Section 1557 Coordinator) is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

- Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html
- This notice is available at Medical Mutual's website: www.MedMutual.com

Questions about your benefits or other inquiries about your health insurance should be directed to Medical Mutual's Customer Care Department at 1-800-382-5729.

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

ACSHP | Allen County Schools Health Plan

Required Notices

IMPORTANT INFORMATION
for all Benefit Eligible Employees

The following Notices are required by the laws surrounding health care plans. Please review these notices. If you have any questions, please contact your Treasurer's office.

Evergreen Election

For those employee benefit programs that allow for employee payroll deductions to be taken on a pre-tax basis, the district's Section 125 Plan allow for such pre-tax deductions. As allowable by law, employee's payroll deductions will be taken on a pre-tax basis unless the employee notifies the Treasurer's office, and completes an election form declining participation. Any change will be effective as of the first day of the new plan year. The salary adjustment amounts will be adjusted automatically to reflect any increase or decrease in the cost of the plans selected. This "evergreen" election applies to all plans as allowable by law to be taken on a pre-tax basis.

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

Your Rights After a Mastectomy

Women's Health and Cancer Rights Act of 1998

Under Federal law, Group Health Plans and health insurance issuers providing benefits for mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

- reconstruction of the breast on which the mastectomy has been performed; and
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications of mastectomy, including lymphedemas;

These services must be provided in a manner determined in consultation between the attending Physician and the patient. Call your Treasurer's office for more information.

Newborns and Mothers Health Protection Act (NMHPA)

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

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

To request special enrollment or obtain more information, contact your Treasurer's office.

The Affordable Care Act

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan does provide minimum essential coverage.

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Patient Protection Disclosure

You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan may designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, you may contact the insurance carrier. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, you may contact the insurance carrier.

Summary of Benefits and Coverage (SBC)

As part of the Affordable Care Act, healthcare companies and group health plans must now provide Summary of Benefits and Coverage documents, or SBCs, to help employers, their employees and their families, understand and compare health plans. The SBC and Uniform Glossary are meant to help consumers understand their healthcare coverage, as well as understand common terms used by health plans. Insurance companies and group health plans must provide SBCs in a standard format, and the SBCs can only differ regarding specific plan benefits. This standard format will make it easier for employers and employees to compare plans and shop for a plan that best meets their needs. The Medical & Prescription Drug SBC will be provided to you during open enrollment.

Additional Required Notices Are Attached:

- No Surprise Billing Model Notice
- HIPAA Notice of Privacy Practices
- CHIP Model Notice
- Notice Regarding Wellness Program
- Summary of Benefits and Coverage (SBC) – *PPACA Requirement*

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It should not be construed as, nor is it intended to provide, legal advice. Laws may be complex and subject to change. This information is based on current interpretation of the law and is not guaranteed. Questions regarding specific issues should be addressed by legal counsel who specializes in this practice area.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing.**" This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

If you believe you've been wrongly billed, or you did not receive the required disclosure form, please contact Customer Service number listed on your Member ID card. Unresolved issues can be directed to the Ohio Department of Insurance Monday through Friday 8 a.m. to 5 p.m. at 800.686.1526 or visit the ODI website to file a complaint.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

If you believe you've been wrongly billed, or you did not receive the required disclosure form, please contact Customer Service number listed on your Member ID card. Unresolved issues can be directed to the Ohio Department of Insurance Monday through Friday 8 a.m. to 5 p.m. at 800.686.1526 or visit the ODI website Surprise Billing Resources | Department of Insurance to file a complaint.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Ohio Department of Insurance Monday through Friday 8 a.m. to 5 p.m. at 800.686.1526.

Visit the ODI website Surprise Billing Resources | Department of Insurance for more information about your rights under federal law.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**ILLINOIS - Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid	MAINE – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: https://bms.wv.gov/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 5/31/2029)

NOTICE OF PRIVACY PRACTICES
PLEASE NOTE: SEE YOUR TREASURER'S OFFICE FOR THE COMPLETED VERSION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") applies to Protected Health Information (defined below) associated with Group Health Plans (defined below) provided by Apollo Career Center to its employees, its employee's dependents and, as applicable, retired employees. This Notice describes how Apollo Career Center, collectively we may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to provide individuals covered under our group health plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be mailed to all policyholders then covered by the Group Health Plan. Copies of our current Notice may be obtained by contacting Maria Rellinger at the telephone number or address below, or on our Website at https://acshp.benefithub.com/.

DEFINITIONS

Group Health Plan means, for purposes of this Notice, the following employee benefits that we provide to our employees, employee dependents and, as applicable, retired employees: major medical coverage, dental coverage, vision coverage, and prescription drug coverage.

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining coverage under the group health plan, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Uses and Disclosures for Payment – We may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or a health plan.

Uses and Disclosures for Health Care Operations – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include activities relating to the creation, renewal, or replacement of your Group Health Plan coverage, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Group Health Plan.

Family and Friends Involved in Your Care – If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim.

Business Associates – At times we use outside persons or organizations to help us provide you with the benefits of your Group Health Plan. Examples of these outside persons and organizations might include vendors that help us process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations.

Other Products and Services – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing Group Health Plan coverage, and about health-related products and services that may add value to your Group Health Plan.

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

Other Uses and Disclosures – We may make certain other uses and disclosures of your PHI without your authorization.

- We may use or disclose your PHI for any purpose required by law. For example, we may be required by law to use or disclose your PHI to respond to a court order.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.

- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for cadaveric organ, eye or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.
- We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.
- And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

In the event that applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as described above, we will restrict our uses or disclosure of your Protected Health Information in accordance with the more stringent standard.

RIGHTS THAT YOU HAVE

Access to Your PHI – You have the right of access to copy and/or inspect your PHI that we maintain in designated record sets. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). Access request forms are available from Apollo Career Center at the address below. We may charge you a fee for copying and postage.

Amendments to Your PHI – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request. Amendment request forms are available from us at the address below.

Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. Accounting request forms are available from us at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your PHI – You have the right to request restrictions on certain of our uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. We are not required to agree to your request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the telephone number or address below.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with us in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION
If you have questions or need further assistance regarding this Notice, you may contact Apollo Career Center's Privacy Office by writing to: Apollo Career Center, Attn: Privacy Officer, 3325 Shawnee Road, Lima, Ohio 45806 or calling 419.998.2912.

EFFECTIVE DATE
This Notice is effective March 4, 2026.

NOTICE REGARDING WELLNESS PROGRAM

Allen County Schools Health Plan Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for blood sugar, cholesterol and triglycerides. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of $25 gift card for participating in the biometric screening. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive $25 gift card.

Additional incentives of up to $30 may be available for employees who participate in certain health-related activities activity challenges, stress relief, weight loss or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Julie Moore, RDN, LD at 419-222-1836 (x120) or julie.moore@staff.allencountyesc.org.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as one-on-one health coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Allen County Schools Health Plan may use aggregate information it collects to design a program based on identified health risks in the workplace, Allen County Schools Health Plan Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) Julie Moore, RDN, LD in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Julie Moore, RDN, LD at 419-222-1836 (x120) or julie.moore@staff.allencountyesc.org.