RESOLUTION APPROVING 2026 HEALTH INSURANCE PRICING AND ADOPTING THE SUMMARY PLAN DESCRIPTION

WHEREAS, the Ashtabula County Board of Commissioners provides group health insurance coverage for eligible County employees; and

WHEREAS, the Human Resources Department, in coordination with IEN Risk Management Consultants and Cigna HealthCare, has presented the 2026 health insurance plan pricing and Summary Plan Description (SPD) for adoption; and

WHEREAS, the Board has reviewed and determined that the proposed plan design and pricing are in the best interest of the County and its employees;

NOW, THEREFORE, BE IT RESOLVED, by the Ashtabula County Board of Commissioners that:

1. The Board hereby approves the 2026 health insurance pricing as presented, effective January 1, 2026.
2. The Board hereby adopts the Summary Plan Description (SPD) for the 2026 plan year.
3. The County Administrator and Human Resources Director are authorized to execute any documents necessary to implement the 2026 health insurance plan with IEN Risk Management Consultants and Cigna HealthCare.

ASHTABULA COUNTY COMMISSIONERS

CERTIFICATION PAGE

Resolution No. 2025-485 **November 04, 2025**

RESOLUTION APPROVING 2026 HEALTH INSURANCE PRICING AND ADOPTING THE SUMMARY PLAN DESCRIPTION

Upon the motion of Casey R. Kozlowski, seconded by Kathryn L. Whittington.

VOTE:

J.P. Ducro IV	**Aye**
Casey R. Kozlowski	**Aye**
Kathryn L. Whittington	**Aye**

CERTIFICATE OF CLERK

IT IS HEREBY CERTIFIED that the foregoing is a true and correct transcript of a resolution acted upon and duly passed by the Board of County Commissioners of Ashtabula County, Ohio, on the date noted above.

Crystal Sturgill, Clerk of the Board /Acting
Board of County Commissioners
Ashtabula County, Ohio

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 1-800-634-0173 or visit us at www.jpfarley.com. 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 www.jpfarley.com or call 1-800-634-0173 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** person / **$2,000** family for Network providers. **$2,000** person / **$4,000** family for Non-Network providers	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. **Preventive care**, and other services as listed below are covered before you meet your **deductible.**	This **plan** covers some items and services even if you have not yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply.
Are there other deductibles for specific services?	No. There are no other specific **deductibles**.	You do not have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	$3,000/person or $6,000/family for In-Network Providers. $6,000/person or $12,000/family for Out-of-Network Providers. This plan has a separate Out of Pocket Maximum of $2,500/person or $5,000/family for Pharmacy services	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?	Prescription Drugs, Premiums, prior authorization and cost containment penalties, **balance billed charges**, amounts over the **allowed amount** or Maximum Allowable, Out of Network Transplants (see plan document) and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the **out–of–pocket limit.**
Will you pay less if you use a network provider?	Yes. For a list of **network providers**, see www.jpfarley.com or call 1-800-634-0173.	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 permission from this plan.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-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	$35 copay, deductible does not apply	50% coinsurance after deductible	----------None----------
	Specialist visit:	$45 copay, deductible does not apply	50% coinsurance after deductible	----------None----------
	Preventive care/screening/ immunization	No Charge	50% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	**Office:** No Charge **Outpatient Hospital**: 30% coinsurance after deductible	50% coinsurance after deductible	----------None----------
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	50% coinsurance after deductible	Complex imaging (MRI, CT/PET scans) require pre-certification.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.disclosedRx.com	Generic drugs (Tier 1)	$15 copay, deductible does not apply (retail) & $30 copay, deductible does not apply (home delivery)	$15 copay, deductible does not apply (retail) & home delivery not covered	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail) and a 30- day supply (retail) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. Out of Pocket Maximum of $2,500/person or $5,000/family for Pharmacy services
	Preferred brand drugs & Non-Preferred Generic Drugs (Tier 2)	$25 copay, deductible does not apply (retail) & $50 copay, deductible does not apply (home delivery	$25 copay, deductible does not apply (retail) & home delivery not covered	
	Non-preferred brand drugs and Generic Drugs (Tier 3)	$35 copay, deductible does not apply (retail) & $70 copay, deductible does not apply (home delivery	$35 copay, deductible does not apply (retail) & home delivery not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs (Tier 4)	Coordinated via Nurse Navigator	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required.
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	----------None----------
If you need immediate medical attention	Emergency room care	$200 copayment, deductible does not apply		Copayment is waived if admitted Emergency Room Doctor and other service No Charge
	Emergency medical transportation	30% coinsurance after deductible		----------None----------
	Urgent care	$50 copayment, deductible does not apply	50% coinsurance after deductible	Includes doctor services. Additional charges may apply depending on the care provided.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required. 60 days/benefit period for Inpatient rehabilitation.
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	----------None----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Office Visit: Outpatient Services:	$35/visit copay, deductible does not apply 30% coinsurance, after deductible	50% coinsurance after deductible	Inpatient services require pre-certification.
	Inpatient services	30% coinsurance after deductible	50% coinsurance after deductible	
If you are pregnant	Office visits	**Initial:** $35/visit copay, deductible does not apply **Other visits**: 30% coinsurance, after deductible	50% coinsurance after deductible	Service must be pre-certified for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay.
	Childbirth/delivery professional services	30% coinsurance after deductible	50% coinsurance after deductible	
	Childbirth/delivery facility services	30% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible	50% coinsurance after deductible	100 visits/benefit period for Home Health and Private Duty Nursing combined. Pre-certification is required.
	Rehabilitation services	**Office:** $45 copay, deductible does not apply **Outpatient Hospital**: 30% coinsurance after deductible	50% coinsurance after deductible	Benefits per Benefit Period: Chiro/Spinal: 12 visits Physical Therapy: 30 visits Occupational Therapy: 30 visits: Speech: 20 visits Pulmonary Rehabilitation: 20 visits Cardiac Rehabilitation: 36 visits
	Habilitation services	**Office:** $45 copay, deductible does not apply **Outpatient Hospital**: 30% coinsurance after deductible	50% coinsurance after deductible	
	Skilled nursing care	30% coinsurance after deductible	50% coinsurance after deductible	Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				an outpatient day rehabilitation program) is limited to 90 days combined per benefit period. Pre-certification is required.
	Durable medical equipment	30% coinsurance after deductible	50% coinsurance after deductible	----------None----------
	Hospice services	30% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required.
If your child needs dental or eye care	Children's eye exam	No Charge	50% coinsurance after deductible	*See Vision Services section
	Children's glasses	Not Covered.		----------None----------
	Children's dental check-up	Not Covered.		----------None----------

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.)

- Cosmetic surgery
- Dental Care (Adult/Child)
- Glasses
- Infertility treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care unless diagnosed with diabetes
- Weight Loss Programs

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

- Acupuncture
- Bariatric surgery (In-Network)
- Chiropractic Care – 12 visits per benefit period
- Private-duty nursing 82 visits/benefit period. 164 visits/lifetime in a Home Setting Only. 100 visits/benefit period combined with Home Health.
- Routine Eye Care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. You may contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information on your rights to continue coverage, contact the claims administrator at 1-800-634-0173.

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: the claims administrator at 1-800-634-0173. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 a sample medical situation, see the next section.

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	$400
Specialist copayment	$45
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$1,000
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	$400
Specialist copayment	$45
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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*	$1,000
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	$400
Specialist copayment	$45
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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*	$1,000
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
ASHTABULA COUNTY BUY-UP PLAN PPO

Coverage Period: 01/01/2026– 12/31/2026
Coverage for: Individual/Family| **Plan Type:** PPO

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 1-800-634-0173 or visit us at www.jpfarley.com. 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 www.jpfarley.com or call 1-800-634-0173 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$400** person / **$800** family for Network providers. **$800** person / **$1,600** family for Non-Network providers	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. **Preventive care**, and other services as listed below are covered before you meet your **deductible.**	This **plan** covers some items and services even if you have not yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply.
Are there other deductibles for specific services?	No. There are no other specific **deductibles**.	You do not have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	$2,000/person or $4,000/family for In-Network Providers. $4,000/person or $8,000/family for Out-of-Network Providers. This plan has a separate Out of Pocket Maximum of $2,500/person or $5,000/family for Pharmacy services	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?	Prescription Drugs, Premiums, prior authorization and cost containment penalties, **balance billed charges**, amounts over the **allowed amount** or Maximum Allowable, Out of Network Transplants (see plan document) and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the **out–of–pocket limit.**
Will you pay less if you use a network provider?	Yes. For a list of **network providers**, see www.jpfarley.com or call 1-800-634-0173.	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 permission from this plan.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-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	$20 copay, deductible does not apply	40% coinsurance after deductible	----------None----------
	Specialist visit:	$30 copay, deductible does not apply	40% coinsurance after deductible	----------None----------
	Preventive care/screening/ immunization	No Charge	40% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	**Office:** No Charge **Outpatient Hospital:** 20% coinsurance after deductible	40% coinsurance after deductible	----------None----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	Complex imaging (MRI, CT/PET scans) require pre-certification.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.disclosedRx.com	Generic drugs (Tier 1)	$15 copay, deductible does not apply (retail) & $30 copay, deductible does not apply (home delivery)	$15 copay, deductible does not apply (retail) & home delivery not covered	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail) and a 30- day supply (retail) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. Out of Pocket Maximum of $2,500/person or $5,000/family for Pharmacy services
	Preferred brand drugs & Non-Preferred Generic Drugs (Tier 2)	$25 copay, deductible does not apply (retail) & $50 copay, deductible does not apply (home delivery	$25 copay, deductible does not apply (retail) & home delivery not covered	
	Non-preferred brand drugs and Generic Drugs (Tier 3)	$35 copay, deductible does not apply (retail) & $70 copay, deductible does not apply (home delivery	$35 copay, deductible does not apply (retail) & home delivery not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs (Tier 4)	Coordinated via Nurse Navigator.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	Pre-certification is required.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	----------None----------
If you need immediate medical attention	Emergency room care	$200 copayment, deductible does not apply		Copayment is waived if admitted Emergency Room Doctor and other service No Charge
	Emergency medical transportation	20% coinsurance after deductible		----------None----------
	Urgent care	$35 copayment, deductible does not apply	40% coinsurance after deductible	Includes doctor services. Additional charges may apply depending on the care provided.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Pre-certification is required. 60 days/benefit period for Inpatient rehabilitation.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	----------None----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Office Visit: Outpatient Services:	$20/visit copay, deductible does not apply 20% coinsurance, after deductible	40% coinsurance after deductible	----------None----------
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Inpatient services require pre-certification.
If you are pregnant	Office visits	**Initial Prenatal**: $20/visit copay, deductible does not apply **Other visits:** 20% coinsurance, after deductible	40% coinsurance after deductible	Service must be pre-certified for vaginal deliveries requiring more than a 48-hour stay and for cesarean section deliveries requiring more than a 96-hour stay.
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	100 visits/benefit period for Home Health and Private Duty Nursing combined. Pre-certification is required.
	Rehabilitation services	**Office:** $30 copay, deductible does not apply **Outpatient Hospital**: 20% coinsurance after deductible	40% coinsurance after deductible	Benefits per Benefit Period: Chiro/Spinal: 12 visits Physical Therapy: 30 visits Occupational Therapy: 30 visits: Speech: 20 visits Pulmonary Rehabilitation: 20 visits Cardiac Rehabilitation: 36 visits
	Habilitation services	**Office:** $30 copay, deductible does not apply **Outpatient Hospital**: 20% coinsurance after deductible	40% coinsurance after deductible	
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				limited to 90 days combined per benefit period. Pre-certification is required.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	----------None----------
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	Pre-certification is required.
If your child needs dental or eye care	Children's eye exam	No Charge	40% coinsurance after deductible	*See Vision Services section
	Children's glasses	Not Covered.		----------None----------
	Children's dental check-up	Not Covered		----------None----------

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.)

- Cosmetic surgery
- Dental Care (Adult/Child)
- Glasses
- Infertility treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care unless diagnosed with diabetes
- Weight Loss Programs

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

- Acupuncture
- Bariatric surgery (In-Network)
- Chiropractic Care – 12 visits per benefit period
- Private-duty nursing 82 visits/benefit period. 164 visits/lifetime in a Home Setting Only. 100 visits/benefit period combined with Home Health.
- Routine Eye Care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. You may contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information on your rights to continue coverage, contact the claims administrator at 1-800-634-0173.

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: the claims administrator at 1-800-634-0173. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 a sample medical situation, see the next section.

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

The plan's overall deductible	$400
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$400
Copayments	$0
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

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

The plan's overall deductible	$400
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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*	$400
Copayments	$1,100
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	$400
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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*	$400
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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

2026 Health Ins Rates

Basic Plan	IEN Cost PEPM	Total Cost Per Year	Employee 10% Share Annual	Emp Cost Per Pay for Payroll	County 90% Share Annual	County Cost Per Pay Payroll
Employee	$805.00	$9,660.00	$966.00	$37.00	$8,694.00	$334.00
Employee + Spouse	$1,832.00	$21,984.00	$2,198.40	$85.00	$19,785.60	$761.00
Employee + Child(ren)	$1,446.00	$17,352.00	$1,735.20	$67.00	$15,616.80	$601.00
Employee + Family	$2,573.00	$30,876.00	$3,087.60	$119.00	$27,788.40	$1,069.00
Buy-Up Plan			**Employee Buy-Up Share**			
Employee	$846.00	$10,152.00	$1,458.00	$56.00	$8,694.00	334.00
Employee + Spouse	$1,968.00	$23,616.00	$3,830.40	$147.00	$19,786.00	761.00
Employee + Child(ren)	$1,568.00	$18,816.00	$3,199.20	$123.00	$15,617.00	601.00
Employee + Family	$2,682.00	$32,184.00	$4,395.60	$169.00	$27,789.00	1069.00