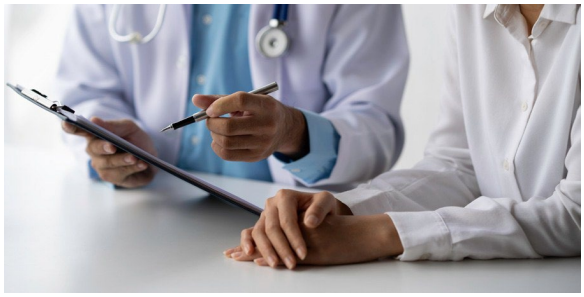
2027
COBRA GUIDE







INSIDE:

- Medical and Prescription Drugs
- Dental Benefits
- Vision Benefits

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What's New!



HSA Plans:

There are two options for HSAs. The Enhanced HSA and the Core HSA. The Enhanced HSA deductible has increased to $3,500 single / $7,000 family. The Core HSA deductible is $6,000 single / $12,000 family.

New medical ID cards:

Those electing new coverage or making changes will receive new ID cards. Those who do not change their coverage will continue with their existing ID cards.



Medical & Pharmacy



Covered Services	PPO 1500	Enhanced HSA	Core HSA
	In-Network	In-Network	In-Network
Deductible (Single/Family) (combined network and non-network)	$1,500 / $3,000	$3,500 / $7,000	$6,000 / $12,000
Out-of-Pocket Maximum (single/family) Includes deductible and coinsurance (combined network and non-network)	$5,500 / $11,000	$4,700 / $9,400	$7,000 / $14,000
Lifetime Maximum (combined network and non-network)	Unlimited	Unlimited	Unlimited
Physician Office Visit/Specialist Office Visit	$30/$50	90%	80%
Immunizations: Baby, Child, Adult	100%	100%	100%
Preventive Care Baby, Child, Adult	100%	100%	100%
Colonoscopy & related services (regardless of diagnosis)	100%	100%	100%
Outpatient Physical Medicine Therapies			
Physical/Occupational Therapy	80%	90%	80%
Speech Therapy (illness, injury, trauma, surgery)	80%	90%	80%
Limited to 20 visits per calendar year			
Chiropractic Manipulations & Office Visits (age 12+) Limited to 20 visits per calendar year	$30	90%	80%
Inpatient Facility Services/Skilled Nursing Facility	80%	90%	80%
Outpatient Surgery Hospital/Alternative Care Facility	80%	90%	80%
Other Outpatient Services Hospital/Alternative Care Facility	80%	90%	80%
Inpatient & Outpatient Professional Charges	80%	90%	80%
LiveHealth Online	$10	90%	80%
Emergency Care/Urgent Care			
Emergency care in emergency room (covers all services, copayment waived if admitted)	$200	90%	80%
Urgent Care facility	$50	90%	80%
Ambulance Services	80%	90%	80%
Maternity Services	$30 initial visit	90%	80%
Mental Health & Substance Abuse			
Inpatient:			
Mental health	80%	90%	80%
Substance abuse	80%	90%	80%
Outpatient:			
Mental Health	$30	90%	80%
Substance Abuse	$30	90%	80%
Human Organ & Tissue Transplants	80%	90%	80%
Medical Supplies, Equipment & Appliances	80%	90%	80%
Prescription Drugs			
Network Retail Pharmacies: Generic/Brand/Non-Brand/ Specialty (30-day supply) *Includes diabetic test strips*	$15/$45/$70/$100	100% before Deductible for preventive Rx (listing available) 90% after deductible for all other Rx	100% before Deductible for preventive Rx (listing available) 80% after deductible for all other Rx
Rx Direct Mail Service: Generic/Brand/Non-Brand (90 day supply) *Includes diabetic test strips*	$30/$90/$140		

Dental



DENTAL BENEFITS

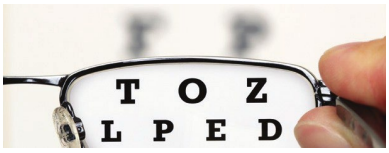
Good dental health is critical to your overall well-being. You may purchase dental insurance that is designed to prevent problems before they occur.

There is no deductible for the dental plan, and preventive and diagnostic services are paid at 100%. In addition, the plan pays 85% of therapeutic and restorative services. Major/complex services are paid at 60% and orthodontic services at 50% (with a lifetime limit of $1,500 on the base plan and $2,500 on the buy-up). Keep in mind, the plan has an annual maximum limit of $1,500 per person on the base plan and $2,000 on the buy-up. All payments are subject to reasonable and customary guidelines. Your dental plan can be purchased on a pre-tax basis using payroll deductions. Please see chart for additional coverage information.

For dental coverage, you may use any dentist you wish. However, your out-of-pocket expenses will be lower if you use a dentist who participates in one of the two Delta Dental of Ohio networks - Delta Dental PPO & Delta Dental Premier. If a member sees an out-of-network provider, they can be balance billed. In the event that treatment is rendered from a dentist that does not participate in any of Delta Dental's programs, the patient may be responsible for more than the percentage indicated below.

Services	Base Options	Buy-Up
Annual Maximum	$1,500 per person	$2,000 per person
Preventive Services Two oral exams and cleanings per year; Bitewing X-ray once per calendar year; Full mouth X-ray once every 5 years.	100% Coverage	100% Coverage
Deductible	No Deductible	No Deductible
Basic Services Oral surgery, root canals, general anesthesia, gingivitis surgery, specified endodontic procedures, periodontal, antibiotic injections, extractions, alveoplasty, routine fillings, filling restorations to diseased/broken teeth, and repair of crowns, inlays, onlays and dentures (with limitations).	85% Coverage	85% Coverage
Major Services Inlays, onlays, gold fillings or crown restorations to repair diseased or accidentally broken teeth (when tooth can not be restored with routine fillings); Initial installation of dentures, bridgework, replacement of bridge or dentures (with limitations); Mouth guards.	60% Coverage	60% Coverage
Orthodontia Braces and related treatments and procedures.	50% Coverage (lifetime max $1,500)	50% Coverage (lifetime max $2,500)

Vision



- Choose an Anthem Blue View Vision network eye care provider at www.anthem.com
- Vision examinations are covered once every calendar year
- Prescription lenses are covered once every calendar year
- Frames are covered once every two calendar years
- Prescription contact lenses are covered once every calendar year

Covered Benefits | Blue View Vision	Base Option	Buy-Up
Vision Examination including dilation and refraction as needed. Covered once every calendar year	$20 copayment	$10 copayment
Prescription Lenses (Pair) Standard plastic lenses up to 55 mm; and all ranges of prescriptions Covered once every calendar year Basic Lenses (pair) Single Vision Lenses (pair) Bifocal Lenses (pair) Trifocal Lenses (pair)	$20 copayment	$10 copayment
Frames Covered once every two calendar years for the base option and once every calendar year for the buy-up option	No copayment, up to $130 retail value	No copayment, up to $150 retail value
Prescription Contact Lenses* Covered once every calendar year Contact Lenses (Elective) (in lieu of eyeglass lenses allowances) Conventional Contact Lenses Disposable Contact Lenses	No copayment, up to $130 retail value	No copayment, up to $150 retail value
Contact Lenses (Non-Elective)	No copayment	

Lens Options	Member Cost for Upgrades
UV Coating	$15
Tint (Solid & Gradient)	$15
Standard Scratch-Resistance	$15
Standard Polycarbonate	$40
Standard Progressive (Add-on to bifocal cost)	$65
Standard Anti-Reflective Coating	$45
Other Add-ons and Services	20% off retail
Transition Lenses	$75
Blue View Vision Additional Savings	
Additional Pair of Complete Eyeglasses	40% off retail**
Eye wear Accessories (Includes some non-prescription sunglasses, lens cleaning supplies, contact lens solutions and eyeglass cases, etc.)	20% off retail price
Laser Vision Correction Surgery	Pay a discounted amount per eye for LASIK Vision Correction. For more information, go to Special Offers at www.anthem.com and select Vision Care

* Professional fitting fees are not a covered service but may be covered or partially covered by applying any remaining contact lens allowance unused for the materials (lens) purchase. Any remaining amount will be applied to the professional fitting fee of the prescribing provider. Contact lens allowance must be used at one time; no amount will be carried forward. If the insured person chooses conventional contact lenses greater than the plan allowance, the insured person will receive a 15% discount toward the difference. If the insured person chooses disposable lenses greater than the plan allowance, the insured person is responsible for the balance.
** Items purchased separately are discounted 20% off the retail price.

2027 Monthly Cobra Premiums



Medical Benefits	PPO Plan	Enhanced HSA	Core HSA
Employee	$923.78	$878.57	$779.43
Employee + Spouse	$2,032.29	$1,932.85	$1,714.77
Employee + Child(ren)	$1,662.81	$1,581.41	$1,403.00
Family	$2,771.31	$2,635.69	$2,338.29

Dental Plan	Basic	Buy-Up
Employee	$28.78	$30.64
Employee + Spouse	$52.98	$61.09
Employee + Child(ren)	$63.57	$88.28
Family	$96.37	$115.08

Vision Plan	Basic	Buy-Up
Employee	$6.39	$8.36
Employee + Spouse	$11.19	$14.66
Employee + Child(ren)	$12.78	$16.74
Family	$23.97	$31.41