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 the Benefits Line at 419-354-1373 or visit http://www.woodcountyohio.gov. 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 https://www.healthcare.gov/sbc-glossary or call 419-354-1373 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$** 150/person or $450/family in-network; $300/person or $900/family out-of-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Pre-Admission Testing and In-Network Second Surgical Opinion	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for the other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	**$**400/person or $1,200/family in-network; $800/person or $2,400/family out-of-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. (Note: **Copayments** do not count toward **deductible**, **coinsurance**, or **out-of-pocket maximums**.)
What is not included in the out-of-pocket limit?	Premiums, copayments, balance-billing charges, penalties for failure to obtain pre-authorization for services and health care this plan does not cover	Even though you pay these expenses, they do not count toward the out-of-pocket limit. Note: **Copayments** do not count toward **deductible**, **coinsurance**, or **out-of-pocket maximums**.
Will you pay less if you use a network provider?	Yes. See frontpathcoalition.com for a list of network providers and locations or call FrontPath at 419-891-5206 or the Benefits Line at 419-354-1373	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 **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. **Copayments** do not count toward **deductible**, **coinsurance**, or **out-of-pocket maximums**.

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	$15 copayment per visit + 20% coinsurance	$15 copayment per visit + 40% coinsurance + balance billing	Copayment applies per office visit regardless of services rendered. Telemedicine limit of 6 visits per calendar year (primary care/specialist combined).
	Specialist visit	$15 copayment per visit + 20% coinsurance	$15 copayment per visit + 40% coinsurance + balance billing	Copayment applies per office visit regardless of services rendered
	Preventive care/screening/ Immunizations	$15 copay/visit + 20% coinsurance	$15 copayment per visit + 40% coinsurance + balance billing	Pap, mammogram, gynecological, prostate – Limited to 1 per year over age 16; Routine colonoscopy maximum: $500 per calendar year if under the age of 45 with routine diagnosis and over age 45 if colonoscopy already performed within a 10-year period.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance + balance billing	Genetic testing: limited to treat a medical condition or for amniocentesis testing only
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance + balance billing	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.woodcountyohio.gov. A Prescription Savings Program is also available to those who are primary on the Plan.	Most Generic drugs, select Over-the Counter drugs, and Vaccinations Tier 1	Retail: $5 copay Mail Order: $10 copay	No coverage	Covers up to a 34-day supply (retail prescription) Up to a 90-day supply (mail order). OTC requires a valid prescription. See Wood County Formulary for limitations and excluded/limited services.
	Preferred Brand drugs Tier 2	Retail: $20 + 20% copay to $45 max Mail Order: $40 copay + 20% copay to $90 max	No coverage	Covers up to a 34-day supply (retail prescription) Up to a 90-day supply (mail order). See Wood County Formulary for limitations and excluded/limited services.
	Non-Preferred Brand drugs Tier 3	Retail: $20 + 20% copay to $85 max Mail Order: $40 + 20% copay to $170 max	No coverage	Covers up to a 34-day supply (retail prescription) Up to a 90-day supply (mail order). See Wood County Formulary for limitations and excluded/limited services.

* For more information about limitations and exceptions, see the Plan Document at www.woodcountyohio.gov.

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 under Medical Necessity Review includes outpatient infusions/injections & drugs over $1,000	Retail: $20 + 50% copay to $200 max -- Mail Order: $40 + 50% copay to $400 max	No coverage	Medical Necessity Review form must be completed by employee & physician and approved prior to purchase. 12-month max. May limit to retail only. **Preauthorization** (precertification) required through Commissioners' Office for outpatient infusions/injections and prescriptions over $1,000
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance + balance billing	**Preauthorization** (precertification) required for outpatient infusions.
	Physician/surgeon fees	20% coinsurance	40% coinsurance + balance billing	**Preauthorization** (precertification) required through Commissioners' Office for outpatient infusions/injections
If you need immediate medical attention	Emergency room care	$45 copayment + 20% coinsurance	$45 copayment, 20% coinsurance + balance billing	Treatment within 72 hours of onset of symptoms for Emergency Medical Care. No coverage for non-emergency care.
	Emergency medical transportation	20% coinsurance	20% coinsurance + balance billing	
	Urgent care	$15 copay + 20% coinsurance	$15 copay + 40% coinsurance + balance billing	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance + balance billing	**Preauthorization** (precertification) required. Semi private room rate.
	Physician/surgeon fees	20% coinsurance	40% coinsurance + balance billing	

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	Outpatient services	$15 copay + 20% coinsurance	$15 copay + 40% coinsurance + balance billing	
	Inpatient services	20% coinsurance	40% coinsurance + balance billing	**Preauthorization** (precertification) required. Semi private room rate.
If you are pregnant	Office visits	$15 copay + 20% coinsurance	$15 copay + 40% coinsurance + balance billing	Depending on the type of services, copayments, coinsurances, or deductibles may apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance + balance billing	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance + balance billing	Semi private room rate. **Preauthorization** (precertification) required within 24 hours for stays in excess of 48 hours for vaginal delivery or 96 hours of C-Section. If the newborn and mother are released at the same time, the newborn's deductible will be waived for the initial routine nursery care. If the newborn's admission is longer than the mother's then charges for routine nursery care of the newborn will be considered as the child's own claim (separate from the mother).
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance + balance billing	120 visits per year
	Rehabilitation services	20% coinsurance	40% coinsurance + balance billing	Occupational & physical therapy combined require Precertification after 15 visits - 30 visits max per calendar year. Strabismus Vision Therapy – 1 course per lifetime 32 visits max
	Habilitation services	20% coinsurance	40% coinsurance + balance billing	Nutritional Counseling – 4 visits per year

* For more information about limitations and exceptions, see the Plan Document at www.woodcountyohio.gov.

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)	
	Skilled nursing care	20% coinsurance	40% coinsurance + balance billing	**Preauthorization** (precertification) required. Semi-private room rate.
	Durable medical equipment	20% coinsurance	40% coinsurance + balance billing	Hearing aids - $3,000 every 4 years; 3 wigs per lifetime; Support/Compression Stockings 3 pair per year when prescribed by physician
	Hospice services	20% coinsurance	40% coinsurance + balance billing	
If your child needs dental or eye care	Children's eye exam	Not Covered		
	Children's glasses	Not Covered		
	Children's dental check-up	Not Covered		

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
- Cosmetic surgery
- Hair loss treatment
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Prescription coverage for excluded/limited services
- Routine dental care
- Routine eye care
- Routine foot care
- Voluntary abortion
- Weight loss programs
- Long-term care

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

- Bariatric surgery
- Chiropractic care
- Hearing Aids/Cochlear Implants (limited)
- Human organ and tissue transplant
- Oral Surgery (limited)
- Private Duty Nursing
- Telemedicine (limited)
- Well Baby Care and Immunizations
- Wigs
- Most coverage provided inside United States

* For more information about limitations and exceptions, see the Plan Document at www.woodcountyohio.gov.

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: Department of Health and Human Service, Center for Consumer Information and Insurance Oversight, 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.

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 Wood County Commissioners' Office Benefits Line at 419-354-1373.

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 the 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-378-1179.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.
Chinese (**中文**): **如果需要中文的帮助**, 请拨打这个号码1-800-378-1179.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-378-1179.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the Plan Document at www.woodcountyohio.gov.

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	$150
Specialist *[cost sharing]*	$15
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Primary care physician 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	$150
Copayments	$30
Coinsurance	$250
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$490**

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

The plan's overall deductible	$150
Specialist *[cost sharing]*	$15
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Specialist 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	$150
Copayments	$200
Coinsurance	$40
What isn't covered	
Limit or exclusions	$20
The total Joe would pay is	**$410**

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

The plan's overall deductible	$150
Specialist *[cost sharing]*	$15
Hospital (facility) *copayment*	$45
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	$150
Copayments	$50
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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