Your Guide to the Wood County Employee Health Benefits Plan

2022 Summary Plan Description • www.woodcountyohio.gov/employee

Welcome to the Wood County Employee Health Benefits Plan

The Commissioners, as Trustees of the Employee Health Benefits Plan (Plan), encourage you to invest in your health and well-being. The Plan offers many cost saving features to help members save money when getting quality care, while protecting the future viability of the Plan.

Coverage is offered to eligible employees through agreements between your Appointing Authority and the Trustees of the Plan. Every department has an Insurance Group Representative who submits information to the Plan on behalf of the Appointing Authority.

Benefits under the Plan are coordinated on a Calendar Year basis (i.e., January - December).

The Plan continues to maintain Grandfathered Status which allows us to continue offering our high quality plan without many burdens of the Affordable Care Act.

This Summary Plan Description summarizes information contained in the Plan Document and approved Plan Amendments regarding the benefits provided in general terms. The Plan Document contains a listing of covered services, exclusions, eligibility, general provisions and Section 125 information.

All documents are available on the employee website, under the Insurance link. If you do not have internet access, copies may be obtained from your Insurance Group Representative or by contacting the Commissioners' Office at 419.354.9100. Visit the website for the most up-to-date information.

Participants will notice a change in the Plan's third party administrator for the health benefits beginning January 1, 2022, as the Plan transitions from Meritain Health to ***Trustmark***. Any medical services received beginning January 1, 2022, will be processed through ***Trustmark***.

Watch for new medical identification cards that will be distributed to Plan members.

No Rate Increase in 2022

The Commissioners were pleased to announce no premium rate increase for coverage in 2022 (same rate on health and prescription coverage since 2016).

Additionally, the Commissioners provided a premium holiday in September 2021 for employees and the employer.

INVEST IN YOU IN '22

The COVID-19 pandemic has brought many changes and with it uncertainty, altered daily routines, financial pressures and social isolation. Information overload, rumors and misinformation can make your life feel out of control and make it unclear what to do. We encourage you to focus on what you can control and take time to invest in your mental and physical health in 2022.

The Employee Assistance Program (EAP) offered through KEPRO can help. The EAP offers virtual visits and is available 24 hours a day by calling 1.800.607.1522.

Find more information about the EAP, along with other available wellness programs in the 2022 Wellness Program Supplement to the Summary Plan Description and on the wellness website, www.woodcountyohio.gov/wellness.

KEEP MORE MONEY IN YOUR POCKET

As a self-insured plan, all premiums collected from the employer and the employee payroll deductions are placed into one "pocket" of money known as the Employee Health Benefits Trust. The Trustees encourage you to be wise consumers when utilizing the benefits provided under the Plan. After all, the Plan's money is your money. Members are encouraged to utilize the money saving features incorporated into the Plan to help keep the "pocket" full. A few examples of ways to save are listed below.

Utilize Network Providers for Maximum Savings: Seeking services from in-network medical and dental providers allows members to stretch their dollars and receive balance billing protection.

Save $ with the Prescription Savings Program: With the cost of prescriptions continuing to rise at a faster pace than medical inflation, the Plan continues its partnership with the Wood County Community Health Center to offer a Prescription Savings Program. Members with primary coverage can receive up to a 90-day prescription for only $5. See Page 10 for more information.

Site of Care for Infusions and Injections: This program helps control rising medication costs and protects the future viability of the Plan.

Precertification is required. Refer to Page 14 for additional information regarding the precertification process.

The Trustees of the Plan believe this non-federal, governmental, self-insured, non-ERISA plan is a "grandfathered health plan" within the meaning of section 1251 of the Affordable Care Act (ACA). As permitted by this Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. While some provisions of the ACA apply to all plans, grandfathered plans may keep their current plan design and do not have to provide certain benefits including preventative care for free.

The Wood County Employee Health Benefits Plan provides minimum essential coverage and meets the minimum value and affordability standards for the benefits it provides. The ACA only applies to health and prescription coverage. The Plan reserves the right to develop and/or modify eligibility rules.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered status can be directed to the Commissioners' Office at 419.354.9100. You may also contact the U.S. Department of Health and Human Services at www.hhs.gov.

Information about the health insurance coverage offered to you and your dependents will be provided on IRS Form 1095-C. Please review this information upon receipt and direct any questions regarding the form to the Benefits Coordinator in the Commissioners' Office.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of enrollment in other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends.

In addition, you may be able to enroll yourself and your eligible dependents if you have a Qualifying Event (e.g., marriage, birth, adoption or placement for adoption, death, change of employment status that results in a gain or loss of insurance eligibility, etc.). Changes must be reported within 30 days of the Qualifying Event. See page 15.

PLEASE NOTE:

When communicating names, addresses and social security numbers for yourself or a dependent, please check to ensure the information matches what is on the individual's social security card.

Upon receipt of your Individual Enrollment Verification Summary, notify your Insurance Group Representative immediately if any corrections are needed. An updated Universal Application may be required to correct the information.

Open Election Period: November 15 through December 15

Benefit eligible employees are automatically re-enrolled in their existing coverage for the following calendar year.

Every year during the annual Open Election period, eligible employees have the opportunity to enroll in, or make changes to, their benefit program without a Special Enrollment Right.

To request a change to your coverage during the Open Election Period, employees must submit a completed Universal Application and any required certification forms to their Insurance Group Representative by December 15. Permitted changes become effective January 1 of the next year.

Annual Insurance Meeting: Nov. 17 - 19

The annual insurance meetings provide an update on Plan performance and tips on how to utilize the benefits in a more cost effective manner. We encourage employees and their family members to attend and continue to be engaged consumers.

As an ongoing precaution, the majority of the Annual Insurance Meetings for employees are scheduled to be held at Job & Family Services in the annex multi-purpose room, in order to maintain social distancing. Employees will be allowed entry to the meetings on a first come first serve basis. The information from these meetings will also be offered in a power point presentation and will be available on the employee website at www.woodcountyohio.gov/employee following the meetings.

The complete meeting schedule can be viewed in the employee newsletter and on the employee website.

INSURANCE BENEFIT ELIGIBILITY

Insurance eligibility is based on employees' Hours of Service with Wood County as required by the ACA. (Hours of Service include hours for which an employee is paid or entitled to payment for the performance of duties. Paid vacation, holiday and sick leave are also included.) Employing departments submit ACA Compliance Reports through an Insurance Group Representative at the time of hire or change in employees hours/status. Following receipt of these reports, benefit eligibility is communicated back to employees. Employee eligibility continues provided eligibility rules are met throughout the calendar year.

Benefit Eligibility	Offer of Coverage
Full Time (ACA) (defined as 30 Hours of Service or more per week, non-seasonal)	Coverage offered upon completion of a 30-day waiting period in full time status and is effective the first day of the next month. Employee must maintain an average of 30 Hours of Service a week per calendar month and will be measured under the Monthly Method until the Standard Look-back Method can be applied. ACA benefit eligible employees are offered Health/Prescription, Vision, Dental and mandatory Life Insurance. Eligible employees along with their legal spouses and dependents, may be covered as long as they meet the Plan's eligibility rules. At any time, the Plan may require proof of eligibility.
Part Time, Seasonal, or Variable Hour (Not ACA full time at the time of hire)	Coverage offer delayed utilizing the Initial Look-back Method to determine benefit eligibility. If benefit eligible, coverage is offered upon completion of a 30-day waiting period and is effective the first day of the next month through the Initial Stability Period. Employees may participate in certain wellness programs offered under the Plan.

Enrollment

During the 30-day waiting period (enrollment period), benefit eligible employees must elect or waive coverage by submitting a Universal Application along with any required certification forms. Completion of a confidential Wellness Awareness Screening is also **required** prior to enrollment for employees and their spouses seeking coverage. Individuals who fail to complete the stated requirements will not be eligible for coverage until the next Open Election Period. A Special Enrollment Right permits enrollment within 30 days of a Qualifying Event for those who initially waived coverage (see Page 2). Also note that the IRS restricts enrollment in other coverage if enrolled in a High Deductible Plan that is partnered with a Health Savings Account (HSA).

Ongoing Eligibility

For benefit eligible employees hired after October 11, 2020, to remain eligible for coverage, an employee's Hours of Service are measured using the **Monthly Method** as listed on Page 4. Failure to meet the eligibility requirement during a month will result in ineligibility for benefits and retroactive termination of benefits for that month if enrolled. Following loss of eligibility, enrollment is reinstated the first day of the month in which the employee meets the eligibility requirement. Employees transition to the Look-Back Method following completion of a full Standard Measurement Period which may take up to 24 months.

For employees hired on or before October 11, 2020, the Plan will determine 2022 eligibility using the **Look-Back Method** Standard Measurement Period from October 11, 2020, to October 9, 2021. Those employees who meet 1,560 Hours of Service during that period will be benefit-eligible for the Standard Stability Period (2022 calendar year) as long as the employee remains an active employee with hours of service during the month of coverage or is on leave protected by FMLA. Coverage terminates at the end of the calendar month in which the employee separates service or changes employment status, provided the employee's portion of the monthly premium is received.

Non-full time and Seasonal employees hired after October 11, 2020, have their Hours of Service reviewed using the **Look-Back Method** Initial Measurement Period which runs 26 full pay periods following the date of hire. Employees will be notified if they measure benefit-eligible following the completion of their Initial Measurement Period.

Special rules apply to employees who are rehired, return from an unpaid leave, or change employment status (e.g., returning employees with a non-retirement break in service of less than 13 weeks will be considered as continuing their employment).

Employee Eligibility Certification Process

Questions regarding your eligibility may be directed to the Benefits Coordinator in the Commissioners' Office at 419.354.9100. The Plan's intent is to comply with current and future Federal guidance on the matter.

The Plan utilizes two Measurement Methods to determine whether an employee is benefit eligible under the Affordable Care Act: Monthly and Look-Back.

Monthly Method: used to count Hours of Service for full time, non-seasonal employees who are enrolled in the Plan and have not completed a full Standard Measurement Period under the Look-Back Method. (Refer to the chart below for Standard Measurement Period dates.)

- Requires an average of 30 Hours of Service per week or more per calendar month until the Standard Stability Period can be applied.
- Eligibility may change month to month - If not eligible for month, coverage will terminate retroactive to the last day of the prior month.
- Employees may be measured monthly for up to 24 months depending on date of employment.

Look-Back Method: used to count Hours of Service for new hires who are Part Time, Seasonal, or Variable Hour, as well as on-going employees. Employees with 1,560 Hours of Service or more during the measurement period are considered benefit-eligible. There are two types of Look-back Methods: Initial and Standard.

Initial Look-Back Method: used for new hires who are part time, seasonal or variable hour who are not benefit eligible at hire.

Standard Look-Back Method: applied to all employees on an annual basis provided they are employed for the full Standard Measurement Period.

Both methods are divided into three parts as defined below:

A **Measurement Period** for counting hours of service.

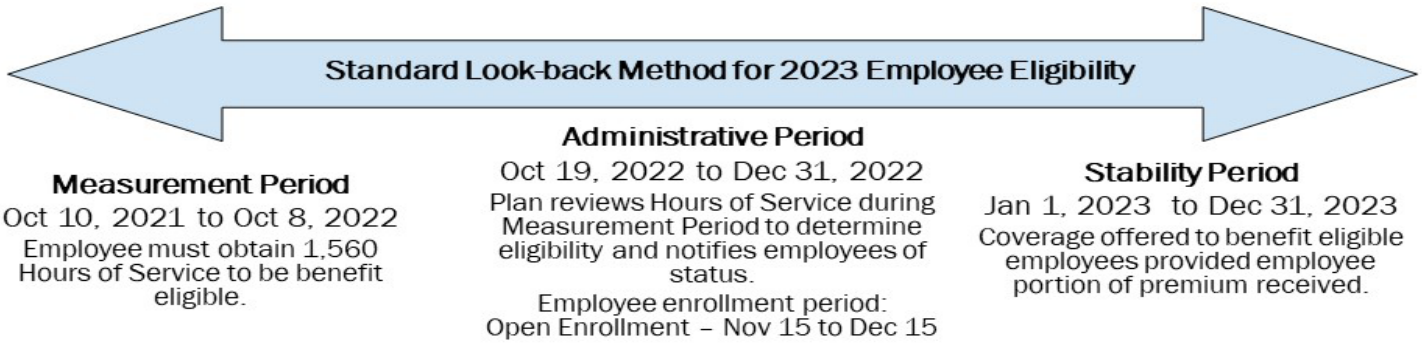
- Initial: First full 26 consecutive pay periods after date of hire.
- Standard: Predetermined by the Plan as listed below.

An **Administrative Period** to determine and communicate eligibility. Benefit eligible employees must elect or waive coverage during this period.

- Initial: Up to 30 days plus the remainder of the month following the completion of the Initial Measurement Period.
- Standard: 90-day period following the Standard Measurement Period.

A **Stability Period** in which an employee is considered benefit eligible or not benefit eligible.

- Initial: First day of the month following the Initial Administrative Period through the next 12 months
- Standard: January 1 to December 31 following the Standard Measurement Period.



2022 Employee Eligibility - Standard Measurement Period
Oct 11, 2020 to Oct 9, 2021

Spousal Eligibility: Health & Prescription, Vision, and Dental

Lawful spouses may be covered on the employee's family coverage. Employees seeking primary coverage for a spouse shall certify spousal income initially and on an annual basis to determine eligibility. Income thresholds are listed below and are based on the spouse's annual adjusted gross income. Primary coverage information is required if seeking secondary coverage through the Plan. Spouses seeking coverage under any benefit **must** complete a wellness screening during the employee's 30-day enrollment period.

Income Less than $26,700	Income $26,700 to $58,400	Income Greater than $58,400
Spouse may be primary under Family Coverage, a spousal premium will not apply.	Spouse may be primary, the spousal premium will apply in addition to the Family Coverage rates listed on Page 6.	Spouse may be secondary under Family Coverage. Primary coverage is not available.

If a spouse's current income is reduced to less than the Spousal Eligibility Level verified during the certification process, an employee may request a temporary exception to the Spousal Eligibility Rules. See the employee website for a copy of the Spousal Eligibility Exception Policy and Procedure for more information regarding deadlines and on-going reporting requirements.

Dependent Eligibility: Health & Prescription

Qualified dependents are eligible for coverage on the employee's family coverage from birth to the end of the month in which they turn 26 -- includes biological son or daughter, adopted son or daughter (includes placement for adoption), step son or daughter.

Dependent Eligibility: Vision and Dental

Qualified dependents are eligible for coverage on the employee's family coverage through the end of the calendar year in which they turn 19. Coverage can continue to end of the calendar year in which they turn 23 if dependent is a full time student (see below).

- Natural, legally adopted children or children placed in anticipation of adoption who are:
  - Unmarried
  - Not employed on a regular full time basis
  - Not covered under the Plan as an employee
  - Dependent on the covered employee or the covered employee's Spouse for more than 50% of their financial support
  - Dependent claimed for tax exemption purposes under Section 152 of the Internal Revenue Code
  - Includes a stepchild or child under legal guardianship of a covered employee or covered employee's spouse who:
    - Meets all the requirements listed above
    - Lives in the covered employee's home for more than half of each calendar year in a regular parent-child relationship
    - Is wholly dependent on the covered employee for financial support
    - Is claimed by the employee as a dependent for tax exemption purposes under Section 152 of the Internal Revenue Code
- Full time student at an accredited school from age 19 until the end of the calendar year in which they reach the limiting age of 23. Must complete the Eligibility Certification Process to verify eligibility. Full time student coverage continues only between semesters/quarters if the student is enrolled as a full time student in the next regular semester/quarter.
- Dependent children with a totally disabling physical or mental handicap may qualify. See the Plan Document for additional information.

These persons are excluded as Dependents:

- other individuals living in the covered employee's home, but who are not eligible as defined;
- the legally separated or divorced former Spouse of the employee (even when a court order has been issued requiring the covered employee to provide health insurance for the divorced Spouse);
- any person who is on active duty in any military service; or
- any person who is covered under the Plan as an employee.

Spousal and Dependent Eligibility Certification Process

In addition to initial certification, the Plan requires annual certification to determine spousal and dependent eligibility. The certification process for the 2022 calendar year is from August 15 to September 15, 2021.

How Premiums Are Collected

Monthly premiums are collected through employer and employee contributions. The employer pays 85% of the total premium. Employees are responsible to pay 15% of the total premium which is collected through payroll deduction.

The employee contribution is collected through payroll deduction that is split between the first and second pay dates of each month. Payroll deductions may be collected on a pre-taxed basis.

Insufficient Wages for Payroll Deduction

During a month in which an employee is enrolled in coverage and the employee's wages are insufficient to collect the employee's portion of the premium for one or both of the scheduled payroll deductions, the payroll deduction will stop and the employee will be required to self-pay the full employee portion of the monthly premium by the last day of the month prior to the month of coverage. Employees in this situation must give five working days advance notice if they choose to continue coverage. If an employee fails to provide proper payment, coverage will terminate retroactive to the first of the month for which payment was not received.

Employees in a Stability Period who lose coverage due to a failure to pay the premium are not permitted to re-enroll in the Plan for the remainder of the Stability Period unless a Qualifying Event is experienced, and retroactive premiums are paid upon re-enrollment.

2022 MONTHLY PREMIUMS

Single Coverage	Total Rate	Employer	Employee	COBRA
Health and Prescription	$609.48	$518.06	$91.42	$621.67
Vision	$8.92	$7.58	$1.34	$9.10
Dental	$32.78	$27.86	$4.92	$33.44
Life*	$8.72	$8.72	$0	N/A
Total	$659.90	$562.22	$97.68	

Family Coverage (2 or more)	Total Rate	Employer	Employee	COBRA
Health and Prescription	$1,584.62	$1,346.92	$237.70	$1,616.31
Vision	$23.20	$19.72	$3.48	$23.66
Dental	$85.20	$72.42	$12.78	$86.90
Life* (Employee Only)	$8.72	$8.72	$0	N/A
Total	$1,701.74	$1,447.78	$253.96	

* Board of DD Employees refer to the Life Certificate.

Spousal Premium Rates

Refer to the Spousal Eligibility section on Page 5 to see if an additional premium applies for spousal coverage. The premium is funded 100% by the employee, collected through payroll deduction and available on a pre-taxed basis. The Spousal Premium is in addition to the employee's portion of the Family Coverage rate listed above.

Health and Prescription	$609.48
Vision	$8.92
Dental	$32.78

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Under Public Law 99-272 Title X, commonly referred to as COBRA, Plan participants no longer eligible for coverage may be eligible to continue coverage at their own expense. Participants are notified of their COBRA rights upon enrollment in the health benefits program. When coverage terminates, employees must complete a COBRA personnel action report form to determine COBRA eligibility. Written communication regarding COBRA offerings shall be mailed to the affected employee and/or spouse and dependents following termination of benefits.

HEALTH COVERAGE

Total Monthly Cost
(Includes Prescription Coverage see page 10)

Single	$609.48
Family	$1,584.62

Employee Payroll Deduction
(1st & 2nd pay of month)

Single	$45.71
Family	$118.85
Spousal Premium	$304.74

Co-Payment
(Not applied to Deductible/Co-Insurance)
Professional (Office Visit)
$15 per visit
Technical (Emergency Room)
$45 per visit

Annual Deductible

In-Network	Out-Of-Network
$150 Single	$300 Single
$450 Family	$900 Family

Annual Co-Insurance

In-Network	Out-Of-Network
80% Plan	60% Plan
20% Subscriber	40% Subscriber

Maximum Annual Co-Insurance Expenses

In-Network	Out-Of-Network
$ 250 Single	$ 500 Single
$ 750 Family	$1,500 Family

Maximum Annual Benefit
Essential services
No limit

Out-of-Network deductible applies to In-Network deductible.

The Plan reserves the right to direct/coordinate care.

Trustmark®
benefits beyond benefits

Phone: 1.800.999.0114
Online: myTrustmarkBenefits.com
App: myTrustmarkBenefits Mobile
Mobile Messaging: Text "JOIN" to 49419.

Summary Schedule of Benefits (See Plan Document for Complete Listing)

Pre-Admission Testing and Second Surgical Opinion (Voluntary/Optional) are covered at 100% and are not subject to the deductible, co-insurance, and co-payment features.

Precertification for services identified in the Plan Document is ultimately the responsibility of the participant. (See page 14 for additional information regarding the precertification process.)

The following services are subject to deductible, co-insurance and co-payments:

- Ambulance
- Anesthesia & Surgical Assistance
- Blood Services
- Breast Reconstruction/Prostheses due to Mastectomy — Coverage provided for a medically necessary mastectomy and election of breast reconstruction after the mastectomy for: reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce symmetrical appearance, and coverage for prosthesis and treatment of physical complications of all stages of mastectomies, including lymphedemas.
- Child Health Supervision Services (Well baby care & immunizations)
- Colonoscopy — one per 10 year period for age 50 or over; any age with family history or medical necessity; or under $500 Wellness Benefit
- Diabetic Nutritional Counseling — 2 sessions per calendar year with Diabetes diagnosis
- Diagnostic X-ray, Laboratory and Pathology Expenses
- Durable Medical Equipment
- Emergency Room — within 72 hours of onset for Emergency Medical Care
- Hospital Services: Inpatient — Precertification required, semi-private room
- Extended Care Facility/Skilled Nursing Facility: Inpatient — Precertification required; semi private room rate
- Hearing Aids — See Plan Document for limit
- Home Health Care — 120 visits per calendar year
- Hospice: Inpatient - Precertification Required
- Human Organ & Tissue Transplant - Precertification required
  The Plan reserves the right to direct payment for transplant services to transplant Centers of Excellence at the Plan's discretion.
- Infusion/Injections: Outpatient - Precertification required (Plan reserves the right to direct site of care)
- Surgical Expenses — may require Precertification
- Maternity: Inpatient - Precertification may be required
  Covered Medical Expenses payable for any hospital stay in connection with childbirth for the mother or newborn child will not be restricted to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the mother's (or newborn's) attending provider may, after consulting with the mother, discharge the mother or her newborn earlier than 48 hours (or 96 hours if applicable).
- Mental, Nervous and Substance Abuse Treatment
- Musculoskeletal Manipulations, Adjustments & Related Modalities — 12 visits per calendar year
- Oral Surgery — must file with dental coverage first
- Orthotic Devices that limit or stop the motion of a weak of diseased body part
- Outpatient Hospital & Surgical Expenses
- Pap Test, Gynecological Exam & Mammogram — one routine per calendar year
- Physician Services — inpatient, outpatient and office surgical procedures
- Physicals/Wellness
- Private Duty Nursing
- Prostate Exam & Screening — one routine per calendar year
- Rehabilitation Services: Inpatient - Precertification Required
- Surgical Procedures for weight control and any related complications or services following these procedures — See Plan Document for limit
- Therapies - Precertification may be required and limits may apply based on type. Chemo; Radiation; Hemodialysis; Speech; Inhalation; Physical & Occupational (limited to 15 visits combined prior to required precertification); Vision (specific diagnosis only)
- Wigs — three per lifetime

When you need immediate care, knowing your options can save you time and money.

Urgent Care vs. Emergency Care (ER)

One of the more difficult health care choices you may be faced with is where to go when you need medical attention for a sudden injury or illness.

Oftentimes, we automatically think we need to go to the emergency room when we need urgent care - assuming that it is our only option for after-hours medical attention. We may also think that since it is open 24 hours a day, we will receive prompt care in an emergency room, but often, the exact opposite is true.

If your injury or illness is minor, you may find yourself waiting for a long time while others with more serious problems are evaluated and treated. Also, a visit to the ER for non-emergency care can cost three to four times more than a visit to an urgent care center for the same ailment and if it is not medically necessary for an ER setting, the bill can become your responsibility.

Always seek immediate emergency care if you believe you are experiencing a medical emergency, one that requires immediate care to avoid severe injury, serious impairment, disability, or death.

Wood County Health Department
Community Health Center

A federally qualified health center, the Community Health Center provides comprehensive primary and preventive care. Located at 1840 East Gypsy Lane, it is an entity of the Wood County Health Department.

Unique benefits realized by establishing primary care at the Wood County Community Health Center include the following:

- Family Practice (Health Care services for your entire family)
- Pharmacy services for Center patients
- Reproductive Health Care
- Social Work Services
- Counseling/Behavioral Health Specialist
- Assistance with enrolling in Marketplace insurance
- Financial Assistance/sliding fee scale for those who qualify
- Non-Wood County residents welcome

Community Health Center Hours*

Monday: 8:30 a.m. - 6 p.m.
Tuesday, Wednesday, Thursday: 8:30 a.m. - 4:30 p.m.
Friday: 8:30 a.m. - 2 p.m.
Pharmacy staff take lunch from Noon - 1 p.m. Monday through Thursday.

Call 419.354.9049 to schedule an appointment.

FALCON HEALTH CENTER

If you cannot get into your doctor and have an urgent need, consider Falcon Health Center. The physicians, nurse practitioners, nurses and medical assistants at the Center provide treatment for minor ailments and injuries that need prompt attention, but don't require a visit to the emergency room. Falcon Health bills at the doctor office rate which is lower than an urgent care facility.

Located at 838 East Wooster Street in Bowling Green, Falcon Health welcomes members of the Wood County community, who are six months and older.

Walk-in patients will be seen on a first come, first serve basis. Co-pays are due at the time of the visit.

Falcon Health Center Hours*:

Monday - Friday: 8 a.m. - 7 p.m. Saturday & Sunday: 9 a.m. - 5 p.m.
Closed on holidays

Phlebotomy (Blood Draw)/Lab: Monday - Friday: 8 a.m. - 4:30 p.m.

Radiology: Monday - Friday: 8 a.m. - 7 p.m.
Saturday & Sunday 9 a.m. - 5 p.m.

Pharmacy: Monday - Friday: 8 a.m. – 6 p.m.(drive-thru window available)
Summer hours may vary.

For more information, or to make an appointment, call 419.372.2271.

* Hours subject to change based on facility needs.

Save Money by Using In-Network Providers

Wood County's medical coverage is self-insured and utilizes a Provider Network to access discounted fees for service. Subscribers will be protected from balance billing if using a network provider.

Provider Network: **FrontPath Health Coalition**

To view a listing of providers in the FrontPath Network visit www.frontpathcoalition.com or call 1.888.232.5800

	In-Network	Out-of-Network
Providers	FrontPath Provider	Non-FrontPath Provider
Deductible	$150 Single $450 Family*	$300 Single $900 Family*
Co-Insurance	80% Plan 20% Subscriber $250 per person	60% Plan 40% Subscriber $500 per person
Co-Payment (Does not count toward Deductible or Co-Insurance)	$15 Professional (Office Visit) $45 Technical (Emergency Room)	$15 Professional (Office Visit) $45 Technical (Emergency Room)
Maximum Out-of-Pocket	$400 Single ($150 Deductible + $250 Co-Insurance) $1,200 Family* ($450 Deductible + $750 Co-Insurance)	$800 Single ($300 Deductible + $500 Co-Insurance) $2,400 Family* ($900 Deductible + $1,500 Co-Insurance)

*Family = based on 3 person maximum

FrontPath Health Coalition: Quality Improvement Portal

The FrontPath Health Coalition's website includes a Cost and Quality Portal where members can compare cost and quality for specific procedures based on providers in the network.

To view the information visit www.frontpathcoalition.com and select the Cost/Quality Compare link. Patient satisfaction ratings are also provided.

For the password to the site, contact your insurance group representative or the Commissioners' Office.

Searching for a New Medical Provider?

The Community Health Center at the Wood County Health Department is accepting new patients for primary care services. By using the Health Center as your primary care provider, members who are primary on the health plan can gain access to the Prescription Savings Program.

Looking for a specialist? Look no further than the Wood County Hospital. Featuring a network of speciality physicians right here in our community, the Wood County Hospital can help keep your health care dollars local. Visit the Wood County Hospital's website at woodcountyhospital.org to search physicians by specialty.

Omnibus Budget Reconciliation Act of 1986 (OBRA)

The Plan is subject to Medicare regulations. OBRA law requires employees to notify the Plan when a Plan participant becomes disabled or reaches age 65. Plan participants must elect primary coverage under this Plan or Medicare. Wood County provides employees/dependents over the age of 65, or disabled, the same group health plan coverage provided for employees/dependents under age 65. Employees must report their election on the Primary Coverage Selection Form (OBRA) which is available on the employee website. The Plan is subject to Medicare regulations.

PRESCRIPTION COVERAGE

PRESCRIPTION SAVINGS PROGRAM

The Prescription Savings Program combines quality medical care for ongoing, routine treatment with a low co-payment for prescription medications: up to a 90-day supply* for $5.

The Program is available to primary Plan members and does not coordinate benefits with other insurance coverage.

To utilize the Prescription Savings Program, the member must transfer primary care services to the Wood County Community Health Center. This grants members full access to the Center's on-site, full service pharmacy.

Members can continue to seek treatment from their specialist who may prescribe medication. The Center's pharmacist can provide information regarding the transition process.

To ensure the effectiveness of a medication, any prescription for a new medication will be limited to a 30-day fill. After that, a 90-day fill will be available with the exception of any prescription over $1,000. Those are limited to a 30-day fill. Note that not all medications are available through this program*.

Questions regarding the program can be directed to the Commissioners' Office at 419.354.9100.

* Some restrictions apply

See Health Coverage for Total Monthly Cost

This self-insured Plan has adopted a Prescription Savings Program along with a prescription formulary identifying drugs that the Plan may consider for payment at participating pharmacies.

PRESCRIPTION FORMULARY

A prescription formulary is utilized for members seeking prescriptions outside of the Prescription Savings Program. Participants are responsible for their co-payment based on the drug tier and the Plan pays the balance.

The formulary identifies those medications most frequently prescribed and places them within tiers to create steerage to effective, lower net ingredient cost drugs. While the drugs in the list can be alternatives for one another, your specific dosage requirements must be determined by your doctor. Note that not all medications are covered under the formulary. The formulary is integrated into the MyDrugBenefit program listed below.

Updates to the formulary are made throughout the year based on market trends resulting in tier and/or coverage changes. While a drug may be listed in the formulary, the drug may fall under the Plan's Excluded and Limited Services.

Generic drugs are required when available, or an added fee is imposed, unless specific instructions from the doctor are given (i.e., DAW - Dispense as written). Approved Over-the-Counter medications listed in the formulary require a valid prescription.

MyDrugBenefit

To see what tier a medication falls under in the formulary, visit MyDrugBenefit. If you are new to MyDrugBenefit, log in from the link provided on the insurance page of the employee website. This will ensure that you are receiving the information specific to the Plan.

MyDrugBenefit, previously known as RxEOB, is an on-line tool that provides members with access to their prescription claims history, a printable list of prescribed medications, formulary listing/drug lookup tool, cost comparisons, drug information, and a pharmacy locator. The site also provides resources on health topics, supplements, medical tests and more.

Medicare Part D

Wood County has determined that this prescription drug coverage is, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage. You can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two month Special Enrollment Period (SEP) to join a Medicare drug plan. For more information about Medicare Prescription Drug Coverage visit www.medicare.gov or 1.800.Medicare or refer to the Plan Document.

PRESCRIPTION CO-PAYMENTS

Prescription Formulary Tier	Prescription Savings Program Co-Payment 90-day supply*	Retail Pharmacy Co-Payment 34-day supply maximum	Mail Order Co-Payment 90-day supply maximum
Tier 1 and select OTC with prescription	$5	$5	$10
Tier 2	$5	$20 plus 20% AWP $45 Maximum	$40 plus 20% AWP $90 Maximum
Tier 3	$5	$20 plus 20% AWP $85 Maximum	$40 plus 20% AWP $170 Maximum

* Some restrictions apply AWP = Average Wholesale Price

Excluded and Limited Services

Subscribers requesting the Plan to pay for drugs not covered may request an exception for coverage through the Medical Necessity Review process. Prior to purchase, the prescribing physician and employee shall complete a Medical Necessity Review form and submit to the Plan for consideration. Forms are available from your Group Representative or on-line. Insufficient or incomplete information may result in a delay or denial of the claim.

If approved by the Medical Manager, the Plan will notify the Subscriber of the effective dates of coverage and any other limitations. In some cases, coverage may be limited to a 30-day supply.

Co-Payment with Prescription Savings Program: $5 for 90-day supply*
Co-Payment at Retail Pharmacy: $20 plus 50% of the AWP - maximum $200 out-of-pocket

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See the Savings with the Prescription Savings Program!

Up to a 90-day supply* = $5 co-pay

Medication Savings Example: Pricing as of 10/5/20

Breo Ellipta Inhaler for Asthma

Location	Co-Payment
Retail Pharmacy 12 - 30-day fills	$45 per month $540 Annually
Mail Order	Not available: Drug > $1,000 Limited to Retail Pharmacy or RX Savings Program
RX Savings Program 4 - 90-day fills	$5 $20 Annually

Members save up to $520 annually.

The Plan saves too! Up to $1,966 per year.

Help bend the trend on rising prescription costs and make the switch to the Community Health Center.

Remember if you have a $0 co-pay card through a manufacturer's program for this or any other prescription, the Plan is still paying its share of the Average Wholesale Price. In this example, while you may have no out-of-pocket cost, the Plan would still pay more than $950 for a three-month supply at pharmacy, compared to $465 for a 90-day supply through the Rx Savings Program.

See if this program can help lower your monthly maintenance prescription costs.

The Rising Costs of Prescription Medications

As you likely know, the cost of prescription medications is rising at an alarming rate. To put these costs into perspective, listed below are the top 10 Therapeutic Drug Classes by Cost from 2020. These medications alone cost the Plan over $1.5 million.

Therapeutic Class	Number of Patients	Gross Cost	Average Gross Cost per Day	Average Gross Cost per Patient	Plan Cost
Psychotherapeutic & Neurological Agents	7	$385,241.71	$305.26	$55,034.53	$381,481.71
Antidiabetics	114	$359,277.93	$7.30	$3,151.56	$323,317.60
Miscellaneous Therapeutic Classes	5	$218,520.89	$105.26	$43,704.18	$212,730.46
Gastrointestinal Agents	20	$155,723.42	$38.35	$7,786.17	$150,285.07
Analgesics – Anti-Inflammatory	231	$144,130.11	$9.94	$623.94	$139,707.34
Antiasthmatic & Bronchodilator Agents	201	$145,276.76	$4.45	$722.77	$124,414.96
ADHD / Anti-Narcolepsy	77	$86,248.95	$3.98	$1,102.12	$77,904.71
Anticoagulants	24	$73,471.39	$11.67	$3,061.31	$66,185.77
Dermatologicals	260	$54,328.08	$4.36	$208.95	$49,153.01
Antidepressants	334	$64,190.60	$.67	$192.19	$48,459.94

The Trustees have implemented several programs to help the Plan bend the trend of these rising costs. Your support and participation in programs such as the Prescription Savings Program help protect the member and the Plan from increased prescription costs. Participation in the Wellness Programs can also help prevent/delay the onset of some health issues, while providing a deductible credit to help lower your medical expenses when you do need to seek services.

STATUS REPORT

2022 Estimated Expenses:	$12,761,387
2021 Estimated Expenses: (updated for Stop Loss)	$11,912,019
2021 Actual Expenses through 10/20:	$8,705,733

As a self-insured plan, Wood County is not required to determine medical loss ratio. Note: Board of DD entered plan on 1/1/17.

2020 Plan Expenses:		$11,173,315
Health:	$8,227,758	
Prescription:	$2,003,273	
Dental:	$484,158	
Vision:	$63,168	
Life:	$32,378	
Wellness:	$58,498	
Administrative:	$304,082	
2019 Plan Expenses:		$11,501,618
2018 Plan Expenses:		$12,356,611
2017 Plan Expenses:		$11,188,775
2016 Plan Expenses:		$9,072,546

Privacy Practices: Notification of Availability

A copy of the Notice of Privacy Practices is available to all Plan participants under the insurance link on the employee website, through your Insurance Group Representative, or from the Commissioners' Office.

The Notice of Privacy Practices describes how protected health information may be used or disclosed by your group health plan to carry out payment, health care operations, and for other purposes that are permitted or required by law.

The Notice also sets out our legal obligations concerning your protected health information, and describes your rights to access and control your protected health information (PHI). The Plan does not share PHI or genetic information with any appointing authority or use the information for employment related purposes.

If a participant wishes to permit his or her spouse or other designee to discuss coverage with the Plan or Plan Administrators, the participant must sign-off permitting the designee access to the protected health information on an annual basis. Under HIPAA regulations, a separate sign-off will be required for the Plan and each Plan Administrator.

Questions should be directed to: Pamela Boyer, Privacy Officer, Wood County Commissioners
One Courthouse Square, Bowling Green, Ohio 43402.
Phone 419.354.9100 Fax: 419.354.1522 pboyer@woodcountyohio.gov

DENTAL COVERAGE

Total Monthly Cost

Single	$32.78
Family	$85.20

Employee Payroll Deduction
(1st & 2nd pay of month)

Single	$2.46
Family	$6.39
Spousal Premium	$16.39

Annual Deductible
$ 100 Per Person

Annual Co-Insurance
80/20% on Class II benefits
50/50% on Class III benefits

Maximum Annual Benefits
$1,500 Per Person

Class I: Covered annually at 100% of the Usual, Customary and Reasonable (UCR) fee and are not subject to the deductible:

- 2 cleanings
- 2 fluoride treatments
- 1 set of bitewing radiographs
- Sealants for children under 14 (limited)

Class II: Covered annually at 80% of the UCR fee after the deductible has been met:

- Radiographs (Full mouth x-rays are a benefit once in a five year period.)
- Oral Surgery
- Minor Restorative Services
- Periodontics
- Endodontics

Class III: Covered at 50% of the UCR fee after the deductible has been met:

- Prosthodontics
- Major Restorative Services
- Orthodontics ($1,500 per person-per lifetime, to the end of the year in which they turn 19) not subject to deductible

A predetermination of benefits is recommended if seeking services in excess of $200.

For a complete listing of excluded and limited services refer to the Plan Document.

DELTA DENTAL®

Save more money and receive higher levels of coverage by using the Delta Dental PPO (Point of Service) plan. Delta Dental's PPO Network of dentists have agreed to accept lower fees as full payment for covered services, saving you and the Plan money. Here's an example of the savings.

Sample Cost for a Crown (not actual cost)	Dental Dental PPO Dentist	Delta Dental PREMIER Dentist
Submitted Fee	$950.00	$950.00
Maximum Allowed	$675.00	$898.00
Coverage Level	50%	50%
Amount Delta Dental Pays	$337.50	$449.00
AMOUNT YOU PAY	$337.50	$449.00

If you are looking for a dentist, be sure to visit the Delta Dental website, www.deltadentaloh.com, and select a PPO provider for maximum savings. The website also allows you to register to use the Consumer Toolkit. You can print an ID card, view the schedule of benefits, view Explanation of Benefits (EOB), and more.

Coordination of Benefits:
Know the Rules When Enrolled in Multiple Plans

- Person holding contract is primary: secondary on other coverage if enrolled in another plan
- If both parents cover children, the birthday rule applies to determine who carries primary coverage. Parent's birthday that comes first in calendar year is primary.
- Primary coverage must be documented to enroll as secondary.
- See the Plan Document for additional information. State and Federal regulations may apply.

Children's Health Insurance Program Reauthorization Act (CHIPRA)

If you or your dependents are NOT currently enrolled in Medicaid or the Children's Health Insurance Program (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 or your children aren't eligible for Medicaid or CHIP, 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 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. You must request coverage within 60 days of being determined eligible for premium assistance.

If the employee or eligible dependent was covered under Medicaid or the Children's Health Insurance Program Reauthorization Act (CHIPRA) at the time of initial enrollment and such coverage subsequently terminates, the employee or eligible dependent must request enrollment in the Plan within 60 days after coverage under Medicaid or CHIP terminates.

If you have questions about enrolling in your employer plan, contact the Benefits Coordinator in the Commissioners' Office at 419.354.9100 or the Department of Labor at www.askebsa.dol.gov or 1.866.444-EBSA (3272).

VISION COVERAGE

Vision coverage is available to help offset costs for annual routine eye exams. Coverage may also be used to assist with payment of lenses, frames, contacts, and refractive surgery to correct refractive errors. Benefits are payable only as primary under this self-insured program.

Total Monthly Cost

Single	$ 8.92
Family	$23.20

Employee Payroll Deduction
(1st & 2nd pay of month)

Single	$0.67
Family	$1.74
Spousal Premium:	$4.46

$200 Retro Reimbursement for Services every 24 months
Current Coverage Period 1/1/22 through 12/31/23

Coverage is limited to the services performed/prescribed by a physician. See the Plan Document for additional information.

Original detailed invoices are required and must be submitted with a Vision Services Claim form.

Claims must be submitted within 90 days after the end of the calendar year in which services were received in order to qualify for reimbursement.

LIFE INSURANCE

$20,000 policy*

Enrollment in the life insurance benefit is mandatory for benefit eligible employees and requires completion of the confidential Mandatory Wellness Screening for enrollment, even if waiving all other benefits. Beneficiary designation will follow state designation unless noted on a Universal Application. Refer to the website for certificate.

Total Monthly Cost* $ 8.72 **Employee Payroll Deduction** $ 0

* Board of DD Employees refer to the Board of DD Employees Life Certificate on the employee website.

Precertification Requirements: Required for Certain Services

The Plan requires precertification for many services including hospitalization, high-dollar outpatient infusions/injections, and other services as noted on Page 7.

The precertification call to the Medical Manager must be made:

- At least seven days before an elective Inpatient Hospital admission. If the Hospital admission is scheduled less than seven days in advance, the notification call must be made no later than 48 hours prior to the admission.
- Within 48 hours, or by the first business day (i.e., non-holidays, Monday through Friday) after an emergency Hospital admission;
- Within 24 hours of being notified of the need for a continuing Hospital stay over 48 hours following vaginal delivery or over 96 hours following a cesarean section.
- Upon being identified as a potential organ or tissue transplant recipient.
- At least 48 hours before receiving any other services requiring precertification.

The participant, the medical provider, or another person that has authorization from the participant is required to phone the Medical Manager to obtain precertification. Even if a medical provider or another person agrees to make this initial notification, the covered employee is ultimately responsible for making sure precertification is done.

Should services be obtained without precertification, the benefit may be reduced to 50% if the member appeals the claim and the services are determined medically necessary.

For additional information, refer to the Plan Document or see the back of your insurance card.

Find it on the Web

www.woodcountyohio.gov/employee

Get the most up-to-date information on the Plan under the Insurance Link on the Employee Website.

- Summary of Benefits and Coverage and Definitions
- Plan Document and Plan Amendments
- Universal Application
- Claim Forms
- Certification Forms
- COBRA Personnel Action Report
- Spousal Eligibility Exception Review Policy and Procedure
- Annual Employee Insurance Meeting Presentations
- Privacy Practices (HIPAA forms) including Authorization to Release Information
- OBRA Primary Election Form
- Mail Order Forms (Rx)
- Request for Medical Necessity Review (Rx)
- Medicare Part D Information
- Network & Plan Administrator Information
- Marketplace Information

Claim Questions? Contact Customer Service

Questions regarding an Explanation of Benefits (EOB) or other claim issue can be directed to the customer service department as noted on the back page of this document.

Prior to calling customer service be prepared with the following information:

- Subscriber's name and Social Security number
- Patient's name
- Provider's name & address
- Date of service
- Nature of the problem
- Copy of explanation of benefits (if received)

Note that the claim processor may require a sign-off permitting the caller access to another family member's protected health information as required by federal HIPAA regulations.

When calling be sure to always note:

- The name of the person you spoke with
- The date of contact
- A brief summary of the explanation provided
- Next steps to resolve the problem
- Who will do the next step

Follow-up is extremely important. Be sure to call back to verify receipt of any missing information. Most of all, be patient. Focus on the facts.

Remember it takes a few weeks to process the paperwork. If the matter is not resolved within a reasonable time frame, contact your Insurance Group Representative for assistance.

Should you wish to appeal a claim, be mindful of the appeal timelines listed in the Plan Document.

30-Day Reporting Period Applies to Report Changes to Coverage

To request a change, submit a completed Universal Insurance Application and any required forms to your group representative within 30 days of the event.

The following are examples of events that require notification to the Plan in order to update your insurance coverage.

If you miss the 30-day reporting period, you may not be able to make the change until the next Open Election period.

- Address change
- Marriage
- Name change
- Birth/Adoption
- Divorce/Legal Separation
- Death of a covered family member
- Coordination of benefits changes (new or changes in other coverage)
- Change of life insurance beneficiary
- Military leave
- Employment status changes: Part time to full time, full time to part time status, or other change in hours
- Medicare eligibility through age or disability
- Expiration of COBRA
- Spouses and/or dependents obtaining or losing other insurance coverage/employment
- Dependents over the age of 19 enrolling or leaving college (vision and dental coverage only)
- Employment termination
- Any other changes that affect the insurance coverage

2022 Wood County Employee Health Benefits

Plan Administrator Information

For eligibility and enrollment questions, contact the Commissioners' Office at 419.354.9100

Health Insurance

Group Number: WB0000-XXX (XXX = sub-group no.)

Third Party Administrator/Claims Processor effective 1/1/22
Trustmark Health Benefits 1.800.999.0114
Mon. - Fri. 8 a.m. to 6 p.m.
www.mytrustmarkbenefits.com

Network
FrontPath Health Coalition
1.888.232.5800 or 419.891.5206
www.frontpathcoalition.com

Precertification & Medical Management effective 1/1/22
UM Department - Trustmark HMC
1.800.999.0114

Claims Submission effective 1/1/22
FrontPath Paper Claims: PO Box 5810; Troy, MI 48007-5810
include Group Number WB0000 to expedite payment
Electronic Claims: FrontPath Coalition: EDI: Emdeon 34171

Appeals
Check the Explanation of Benefits for appeal timelines.
Submit to: Trustmark Health Benefits,
PO Box 2920, Clinton, IA 52733-2920

Prescription Insurance

Group Number: 99990368-XXX

Administrator/Claims Processor
Pharmacy BenefitDirect
1.800.806.7859
Mon. – Fri. 8:30 a.m. to 10 p.m. & Sat. 9 a.m. to 5 p.m.
www.pdmi.com
Pricing information available at MyDrugBenefit. See link on employee website under Insurance
Claims Submission: RX Bin 610020 (PDM), PO Box 5300, Poland, OH 44514

Mail Order Program
Postal Prescription Services (PPS)
1.800.552.6694
Mon. – Fri. 6 a.m. to 6 p.m. PST
Sat. 9 a.m. to 2 p.m. PST
www.ppsrx.com
Claims Submission: PO Box 2718, Portland, Oregon 97208-2718

Additional Programs Available to Employees

Payroll deduction is available for the following optional programs. Enrollment is managed through the contacts listed below.

Ohio Deferred Compensation:
Stan Mories moriess@nationwide.com 419.560.0644

County Commissioners Association of Ohio Deferred Compensation:
Joel Smith joel.smith@empower-retirement.com
844.446.8658 ext. 23704

AFLAC: Charles Polizano charles_polizano@us.aflac.com
419.409.1336

Vision Services Plan

Group Number: XXX

Administrator/Claims Processor
Commissioners' Office
419.354.9100
Mon. - Fri. 8:30 a.m. to 4:30 p.m.
See your Insurance Group Representative for claims submission and questions.

Dental Insurance

Group Number: 1395-1XXX

Administrator/Claims Processor
Delta Dental of Ohio
1.800.524.0149
Mon. – Fri. 8:30 a.m. to 7:55 p.m.
www.deltadentaloh.com
Automated Line: 1.800.282.0749
Available 24 hours - Offers benefit, eligibility, time limitation, participating dentists and claim information

Claims Submission:
Delta Dental of Ohio, PO Box 9085
Farmington Hills, MI 48333-9085

Life Insurance

Administrator/Claims Processor
MetLife

Plan Trustees

Board of County Commissioners
419.354.9100

General Information

The Plan Document, amendments, and forms are available to view or download from the employee website.

www.woodcountyohio.gov/employee

Kepro™

Employee Assistance Program
1.800.607.1522
www.eaphelplink.com
Company Code: WEBEAP
Free & Confidential
Available 24/7/365