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 419.354.9100 or visit www.woodcountyohio.gov/employee. 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 419.354.9100 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 $900/family out-of-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Pre-Admission Testing and Second Surgical Opinion.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	**$** 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?	**$**250/person or $750/family in-network; $500/person or $1,500/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.
What is not included in the out-of-pocket limit?	Premiums, copayments, deductibles, 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.
Will you pay less if you use a network provider?	Yes. See www.co.wood.oh.us/ employee for a list of primary and wrap-around network providers and locations or call 419.354.9100 or	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	$15 co-pay/visit + 20% coinsurance	$15 co-pay/visit + 40% coinsurance + balance billing	
	Specialist visit	$15 co-pay/visit + 20% coinsurance	$15 co-pay/visit + 40% coinsurance + balance billing	
	Preventive care/screening/ immunization	$15 co-pay/visit + 20% coinsurance	$15 co-pay/visit + 40% coinsurance + balance billing	Pap, mammogram, gynecological, prostate – Limited to 1 per year over age 16; Routine colonoscopy – 1 every 10 years over age 50; $500/Adult Wellness annual maximum
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance + balance billing	
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance + balance billing	
	Most Generic drugs and select Over-the Counter 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

* For more information about limitations and exceptions, see the plan or policy document at www.woodcountyohio.gov/employee.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.woodcountyohio.gov/employee. A Prescription Savings Program is also available to those who are primary on the Plan.				order). See Wood County Formulary for limitations and excluded/limited services.
	Specialty drugs under Medical Necessity Review	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 for outpatient infusions.
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	
If you need immediate medical attention	Emergency room care	$45 copay + 20% coinsurance	$45 copay, 20% coinsurance + balance billing	Treatment within 72 hours of onset of symptoms for Emergency Medical Care.
	Emergency medical transportation	20% coinsurance	20% coinsurance + balance billing	
	Urgent care	$15 copay + 20% coinsurance	$15 copay + 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 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	
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, co-payments, 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	**Preauthorization** (precertification) required. Semi private room rate.
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

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)	
	Habilitation services	20% coinsurance	40% coinsurance + balance billing	Diabetic Nutritional Counseling – 2 visits per year with diabetic diagnosis
	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 48 months; 3 wigs per lifetime
	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
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription coverage for excluded/limited services
- Routine dental care
- Routine eye care
- Routine foot care
- Transsexual surgery
- Voluntary abortion
- Weight loss programs

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
- Human organ and tissue transplant
- Most coverage provided inside United States
- Oral Surgery (limited)
- Private Duty Nursing
- Well baby care and immunizations
- Wigs

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.

* For more information about limitations and exceptions, see the plan or policy document at www.woodcountyohio.gov/employee.

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 at 419-354-9100.

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 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.

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 or policy document at www.woodcountyohio.gov/employee.