RESOLUTION NO. 20-2114

In the matter of authorizing Plan Amendments for the	)	County Commissioners' Office,
Prescription program and network changes to the	)	Wood County, Ohio
Wood County Employee Health Benefits Plan.	)	January 30, 2020

WHEREAS, the trustees of the Wood County Employee Health Benefits Plan (the Plan) believe that they are a Grandfathered Health Plan within the meaning of Section 1251 of the Affordable Care Act and provide Minimum Essential Coverage and meet the Minimum Value Standard; and the Plan has adopted benefit eligibility rules in compliance with the Affordable Care Act in Resolution No. 15-1366 authorized on December 15, 2015; and

WHEREAS, changes to the prescription drug program effective November 1, 2019, and the health network effective January 1, 2020, under the Plan have been incorporated in the Plan Document as outlined on Attachment A & B; and

WHEREAS, Jason Beaver, Insurance Consultant from Mercer, having reviewed the changes and liability for the Plan, recommends that the Board consider the changes as listed in the attached Plan Amendments; and

WHEREAS, Consultant Jason Beaver recommends that the insurance program changes be modified to reflect the information provided in the attached Plan Amendments as Attachment A & B, to preserve and protect the long term viability of the insurance trust fund; and

WHEREAS, the Board has considered the recommendations presented on behalf of Consultant Jason Beaver, the Board concurs with said recommendations; therefore, be it

RESOLVED, by the Board of County Commissioners of Wood County, Ohio, that that the above recommendation is authorized for the Plan, as Attachment A & B; and be it further

RESOLVED, by the Board of County Commissioners, as trustees of the Plan support that employees receive said information for continued employee engagement in their health care plan, and be it further

RESOLVED, that the provisions of this resolution shall remain in full force and effect unless otherwise provided for by the said Board.

Commissioner Lahote moved and *Commissioner* Bowlus seconded the resolution and the roll being called on its adoption, the vote resulted as follows:

DR. THEODORE H. BOWLUS yes CRAIG LAHOTE yes DORIS I. HERRINGSHAW, Ed.D. yes

Attest: Sandy A. Ling
Clerk of said Board

ca

cc: County Auditor
file (2)

ATTACHMENT B

SUMMARY OF MATERIAL MODIFICATION AND AMENDMENT #1-20 TO THE WOOD COUNTY EMPLOYEE PLAN

This Summary of Material Modification and Amendment describes amendments to the Wood County Employee Plan dated January 1, 2006. These changes are effective as of **January 1, 2020** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

Wood County (the "Plan Sponsor") is amending the Wood County Employee Plan (the "Plan") as follows:

1. *The **Choice of Providers**, the **How to Obtain Health Care Benefits**, and the **Provider Reimbursement** subsections **under Section VIII. General Provisions** are hereby deleted and replaced as follows:*

VIII. GENERAL PROVISIONS

Choice of Providers

The Wood County Employee Health Care Benefits Plan contracts with a Provider Network to access discounted fees for service for Covered Persons.

Provider Network. To receive benefits paid at the highest level Participants should use a provider in the Provider Network. **A 20% penalty will apply to those services received from a non-network Provider.** Participants will be protected from balance billing if using a Provider in this network.

What does this mean?

1. Depending on the service area, Hospitals, Physicians and other medical providers who have contracted with the Provider Network (as listed on the Plan Administrator's Information Sheet) are called Network Providers. Those who have not contracted with the network are referred to in this Plan as Non-Network Providers. The Plan provides different levels of benefits based on whether the provider that is used is a Network or Non-Network Provider.

2. Unless one of the exceptions shown below applies, the Non-Network level of benefits is payable if a Covered Person elects to receive medical care from a Non-Network Provider. The Non-Network level of benefits is described in detail in the Schedule of Benefits and subsequent pages. Keep in mind that, since there is no network negotiating and limiting the fees the provider may charge, if the charge billed by a Non-Network Provider for any Covered Service is higher than the Reasonable Charge determined by the Plan, the covered employee is responsible for the excess. To receive benefit consideration, claims must be submitted to the Third Party Administrator.

3. If a Covered Person elects to receive medical care from Network Providers, the Plan provides an increased level of benefits for most services. The Network level of benefits is described in the Schedule of Benefits and subsequent pages. In addition, since Network Providers have agreed to accept the negotiated fee as full payment for their services, the covered employee is not responsible for any billed amount that exceeds the Reasonable Charge. These Providers have also agreed to bill the Plan directly, so the Covered Person does not have to submit claims himself.

(Neither the Network Provider discounted fees nor the Network Provider claims filing provisions apply for Covered Persons for whom Medicare is the primary payer.)

Although benefits are available for services provided by any qualified health care provider that meets the Plan's definitions, keep the following points in mind:

1. Only those providers included in the Provider Network qualify for the Network level of Benefits. There are limited exceptions to this general rule, however:

    - The Network Provider level of benefits is payable for covered **ancillary services** (for example, radiology, pathology, anesthesiology) performed by a Non-Network Provider for a Covered Person receiving care on an Inpatient or Outpatient basis at a Network Hospital.

    - The Network Provider level of benefits is payable for covered **lab services** performed by a Non-Network independent lab facility upon the **referral of a Network Physician** in connection with and as a result of a Covered Person's visit to that Physician's office.

    - The Network Provider level of benefits is payable when a Covered Person receives Emergency Care at a Non-Network Hospital for an **Accidental Injury** or a **Medical Emergency**. A Medical Emergency is the sudden and unexpected onset of a medical condition requiring immediate medical attention. Medical Emergencies include heart attacks, strokes, loss of consciousness or respiration, convulsions and other acute conditions that the Plan determines to be Medical Emergencies. The Plan will consider a condition to be a Medical Emergency only if:

        - severe symptoms occur suddenly and unexpectedly;
        - immediate care is secured; and
        - the illness or condition, as finally diagnosed or as indicated by its symptoms, is one that would normally require immediate Medical Care.

    - If the type of Provider needed is not represented on the Network Provider list, the Network Provider level of benefits is payable when the Medical Manager, **pre-approves** the use of a Non-Network Provider of that type. For example, if there are no Licensed Physical Therapists (LPT) on the Network list, the Network level of Benefits will be paid for Covered Services of a Non-Network LPT if pre-approved by the Medical Manager.

In the event there is no availability within a Provider Network, Covered Services will be payable at the Network level of benefits as determined by the group health plan. The network must not have the provider or provider's specialty within a 35-mile radius of the Participant's home address and zip code.

How To Obtain Healthcare Benefits

The Covered Person or the Provider must file claims for Benefits under this Plan with the Third Party Administrator/Claims Processor. Filed means that the claim has been received by the Third Party Administrator. The Employer will provide the necessary forms and information to file claims.

Claim Forms

Claim forms are available from most Providers, Group Representatives, or by contacting the Third Party Administrator's customer service department.

Notice of Claim

The Plan is not liable for consideration and/or payment of any claim, unless it receives written notice that Covered Services have been received by a Participant. The notice must be given within 12 months of receiving the Covered Services, and must have the data the Plan requires to determine benefits. An expense is considered incurred on the date the service or supply was given.

Note: Under Ohio law, patients have the right to obtain an itemized copy of their billed charges from the Hospital or Facility that provided services.

Provider Reimbursement

Benefits shown in the Plan Booklet or the Schedule of Benefits for Covered Services may vary depending on whether the Provider is a Network Provider. If Covered Services are received at a Non-Network Hospital, other than for Emergency Services, the amount of the charge eligible for reimbursement may vary. The actual amount payable is further reduced by any Deductible, Co-payment, Co-insurance or limits that apply to that Covered Service as stated in the Schedule of Benefits.

The Plan at its sole discretion, can designate that payment be increased to the level used for a Network Hospital for all or some Hospital Services performed by a Non-Network Hospital. Providers who have a reimbursement agreement with the Plan's Provider Network(s) (Network Providers) have agreed to accept a negotiated amount as payment in full.

Except as otherwise required under state or Federal regulations, the maximum amount the plan is obligated to pay for services provided by a non-primary PPO provider will be the lesser of the provider's billed charges for covered services and an amount determined by one or more of the following, which we may sometimes modify to maintain the reasonableness of the Allowed Amount:

1. Using current publicly-available data reflecting fees typically reimbursed to providers for the same or similar professional services, adjusted for geographical differences where applicable.

2. Using current publicly-available data reflecting the costs for facilities providing the same or similar services, adjusted for geographical differences where applicable, plus a margin factor.

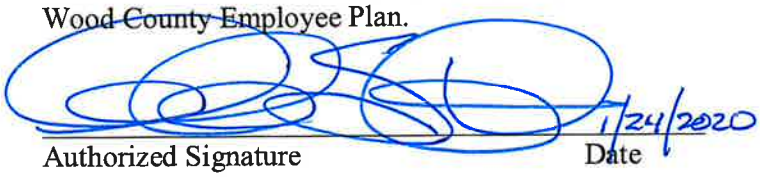
3. Using amounts calculated based on what Medicare would reimburse for the services billed.

Coordination of Benefits

Coordination of Benefits for the Health Benefits Program follows those provisions outlined in the General Provisions section under Coordination of Benefits.

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, Wood County has caused this Amendment to take effect, be attached to, and form a part of Wood County Employee Plan.



Authorized Signature	1/24/2020 Date	COUNTY ADMINISTRATOR Title
Witness	1/24/2020 Date	BENEFITS COORDINATOR Title

ATTACHMENT A

SUMMARY OF MATERIAL MODIFICATION AND AMENDMENT #2-19 TO THE WOOD COUNTY EMPLOYEE PLAN

This Summary of Material Modification and Amendment describes amendments to the Wood County Employee Plan dated January 1, 2006. These changes are effective as of **November 1, 2019** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

Wood County (the "Plan Sponsor") is amending the Wood County Employee Plan (the "Plan") as follows:

1. *The **What other services require Pre-Certification?** subsection **under Section III. Health Care Benefits** of the **Medical Management** section is hereby deleted and replaced as follows:*

III. HEALTH CARE BENEFITS

Medical Management Services

What other services require Pre-Certification?

In addition to Inpatient confinements (including Skilled Nursing Facility, Extended Care Facility and Rehabilitation confinements), all of the following non-emergency services MUST be pre-certified by the Medical Manager:

- Chemotherapy - all settings including services rendered in a Physician's office (penalty does not apply)
- Dialysis - all settings including services rendered in a Physician's office (penalty does not apply)
- Hospice care (Inpatient)
- Occupational therapy and Physical therapy (in excess of 15 combined visits per Calendar Year)
- Radiation - all settings including services rendered in a Physician's office (penalty does not apply)
- Transplants

See the Prescription Drug Benefits section for information on pre-certification for high cost outpatient prescriptions/infusions.

2. *The **Schedule of Benefits** under **Section IV. Prescription Drug Benefits** is hereby deleted and replaced as follows:*

IV. PRESCRIPTION DRUG BENEFITS

Schedule of Benefits

Retail Pharmacy Co-Pay Amount Maximum 34 day supply	
Tier 1 – Generic Drug or Select Over-the-Counter (OTC) Drugs	$5 co-pay per prescription or refill
Tier 2 - Preferred Brand Name Drug	$20 co-pay plus 20% of the Average Wholesale Price (AWP) - $45 maximum out-of-pocket
Tier 3 – Non-Preferred Brand Name Drug	$20 co-pay plus 20% of the Average Wholesale Price (AWP) - $85 maximum out-of-pocket

Benefits apply for prescriptions purchased at Participating Pharmacies only. No Benefits are payable for prescription drugs purchased at Non-Participating Pharmacies.

NOTE: High cost Prescription Drugs exceeding $1,000 per 30-day supply must be approved by the Plan Administrator before dispensing. If approved, the Plan will determine the purchase point and will direct the member to the Site of Care Program Facility for administration. Questions regarding obtaining approval can be directed to the Commissioners' Office at (419) 354-9100.

Mail Order* Co-Pay Amount Maximum 90 day supply	
Tier 1 – Generic Drug or Select Over-the-Counter (OTC) Drugs	$10 co-pay per prescription or refill
Tier 2 - Preferred Brand Name Drug	$40 co-pay plus 20% of the Average Wholesale Price (AWP) - $90 maximum out-of-pocket
Tier 3 – Non-Preferred Brand Name Drug	$40 co-pay plus 20% of the Average Wholesale Price (AWP) - $170 maximum out-of-pocket

***Mail Order Drugs:** Initial: Original prescription must be obtained from your physician. Allow 14 days mail time. Refills: May be obtained by calling a toll free number or online; see Wood County Employee's Plan Administrators' Information Sheet.

Benefit Percentage	The Plan pays all Covered Charges incurred in excess of your co-pay amount.

3. *The following language is hereby added under* ***Covered Benefits*** *of* ***Section IV. Prescription Drug Benefits*** *as follows:*

IV. PRESCRIPTION DRUG BENEFITS

Covered Benefits

Prescription Drug Outpatient Site of Care Program
The Plan has established a designated facility for the administration of outpatient high cost infusion/injection prescription medications. These medications must be approved through the Medical Necessity Review Process. This program is mandatory for patients receiving outpatient infusion/injection/treatment through the Plan's medical/prescription benefits.

Participation in the Site of Care Program will require that patients pre-certify high cost outpatient infusion & injection services by notifying the Wood County Plan Benefits Department for prior approval on these services. For more information contact the Benefits Department as listed in the General Plan Information section.

Prescription Savings Program
The Plan has partnered with the Wood County Community Health Center ("Center") to identify possible cost savings in your Prescription Drug coverage (including those approved under the Medical Necessity Review Process).

In order to participate in the Prescription Savings Program, Covered Persons must transfer primary care services to the Center which then grants full access to the Center's on-site, full service pharmacy.

The Plan will authorize 90-day fills at $5 through the Prescription Savings Program for all prescriptions, with the exception of the first fill of a Prescription Drug prescribed for a Covered Person and for Prescription Drugs in excess of $1,000. These exceptions are both limited to 30-day fills.

Note that not all medications are available through this program.

Questions regarding the program can be directed to the Commissioners' Office at (410) 354-9100.

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, Wood County has caused this Amendment to take effect, be attached to, and form a part of Wood County Employee Plan.

Authorized Signature	1/24/2020 Date	COUNTY ADMINISTRATOR Title	
Witness	1/24/2020 Date	BENEFITS COORDINATOR Title	