Discounts Available To Employees

Some of these discounts overlap, so please look for your best deal. Below is a description of the discounts available:

ComPsych/Working Advantage

This is available to all full-time Wayne County and sub-group employees. ComPsych, our EAP provider, offers a variety of online discounts to hotels, theme parks and attractions, movies, shows and events, water parks, rental cars and more. You will need to visit the following web page and register, in order to receive discounts and savings: https://www.workingadvantage.com/GuidanceResources

Cleveland Playhouse Square

This is available to all Wayne County and sub-group employees. Purchase tickets before the general public and receive discounts to select shows at https://tickets.playhousesquare.org/G04. Click on the link under "How to Purchase Your Tickets" and use the promotion code WAYNECOUNTYOH.

Dunham Sports

This is available to all Wayne County and sub-group employees. Text "WAYNE" to 78557 or download the flyer from wayneohio.org/employee-discounts and show it at the register to receive a discount.

Akron RubberDucks

This is available to all Wayne County and sub-group employees. Each year in July employees have the opportunity to purchase discounted tickets to an Akron RubberDucks baseball game (specific date is announced each year). Also, one lucky person will be chosen to throw a ball from the pitcher's mound! Information will be emailed to your Appointing Authority or supervisor, so please check with them in May or June if they haven't forwarded an email to you regarding this fun event!

Visit https://www.wayneohio.org/employee-portal/employee-discounts/ in order to see additional discounts available to employees. Note that some discounts are also available to part-time employees and those not on the health plan.

Updated 1/1/2024

OFFICE OF THE
WAYNE COUNTY
COMMISSIONERS
Ron Amstutz ★ Jonathan Hofstetter ★ Sue A. Smail

NOTICE TO WAYNE COUNTY EMPLOYEE BENEFIT PLAN PARTICIPANTS

October 1, 2023

The Federal Health Insurance Portability and Accountability Act, in general, impose the following requirements and/or limitations on group health plans:

1. Limitations on pre-existing conditions exclusion periods (146.111).
2. Special enrollment periods for individuals (and dependents) losing other coverage (146.117).
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status (146.121).
4. Standards relating to benefits for mothers and newborns (Section 2704 of the PHS Act).
5. Parity in the application of certain limits to mental health benefits (Section 2705 of the PHS Act).
6. Required coverage for reconstructive surgery following mastectomies
7. Coverage of dependent students on a medically necessary leave of absence

The Federal Health Insurance Portability and Accountability Act gives the plan sponsor of a non-Federal governmental plan the right to exempt the plan in whole or in part from the requirements described above. As of January 1, 2014 we are no longer eligible to exempt our plan from items 1 thru 3 above.

The Wayne County Employee Benefit Plan has elected to exempt all of its Medical, Dental and Prescription plans from item numbers 4 thru 7 above. Wayne County currently provides, and plans to continue to provide, benefits as good, or better, than required for these categories; but in order to protect ourselves from future amendments of these provisions, we are electing to opt out of the requirement to provide these items. These exemptions have been sent to the Health Care Financing Administration (HCFA) for the Wayne County Employee Benefit Plans.

Recent legislation collectively known as Federal Health Care Reform may affect our ability to exempt some or parts of some of the above items. We are sending you this notice to let you know that where we still have authority to exempt the above items, we have exercised our right to do so.

THIS LETTER DOES NOT REQUIRE ANY ACTION ON YOUR PART. If you have any questions about this notice, please contact the following:

The Wayne County Benefit Plan
Attention: The Plan Administrator
428 West Liberty Street
Wooster, Ohio 44691

Important Notice from Wayne County Employee Benefit Plan About Your Prescription Drug Coverage and Medicare

10/1/2023

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Wayne County Employee Benefit Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Wayne County Employee Benefit Plan has determined that the prescription drug coverage offered by all of our plans are on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is 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.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Wayne County Employee Benefit Plan coverage will not be affected. If you are a covered employee in one of our plans we will be primary in most cases to any Medicare coverage you elect.

If you do decide to join a Medicare drug plan and drop your current Wayne County Employee Benefit Plan coverage, be aware that you and your dependents may or may not be able to get this coverage back depending on the circumstances at that time.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with The Wayne County Employee Benefit Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact the Wayne County HR Director at (330) 287-5409. NOTE: You'll get this notice each year. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare if you are eligible for Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- ☐ Visit www.medicare.gov
- ☐ Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- ☐ Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember!

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Special Enrollment Notice

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides employees additional opportunities to enroll in a group health plan if they experience a loss of other coverage or certain life events.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, please contact your payroll person or Marcy Stoller, Benefits Specialist at 330-287-5410 or mstoller@wayneohio.org.

https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-c.pdf

Updated 10/7/2022

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please contact Misty White, Wellness Nurse at 330-287-5487 or wellnessnurse@wayneohio.org.

Updated 10/7/2022

Notice Regarding Wellness Program

The **Health First Wellness Incentive Program** is a voluntary wellness program available to all employees on the Wayne County Health Plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to earn points each year by participating in certain activities, and also complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for current lipid panel numbers, blood sugar number, and your current blood pressure reading. This is to determine your risk for high cholesterol, high blood pressure and diabetes. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of lower deductibles, lower coinsurance and lower copays. Although you are not required to earn points, complete the HRA, or participate in the biometric screening, only employees who do so will receive lower deductibles, lower coinsurance and lower copays.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as wellness programs to keep you healthy, periodic check-ins to stay on top of your health condition (such as high blood pressure), physicals or other services offered at the Employee Health Clinic by either the Wellness Nurse or the Nurse Practitioner. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although Wayne County and the Health First Wellness Incentive Program may use aggregate information it collects to design a program based on identified health risks in the workplace, the Employee Health Clinic and/or the Health First Wellness Incentive Program, including any of its employees, will never disclose any of your personal information either publicly or to Wayne County as the employer, except as necessary to respond to a request from you or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the Employee Health Clinic and/or the Health First Wellness Incentive Program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Health First Wellness Incentive Program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the Health First Wellness Incentive Program. Anyone who receives your information for purposes of providing you services as part of the Health First Wellness Incentive Program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are the Nurse Practitioner, the Wellness Nurse and the Receptionist, all who work within the Employee Health Clinic, in order to provide you with services under the Health First Wellness Incentive Program.

In addition, all medical information obtained through the Employee Health Clinic and/or the Health First Wellness Incentive Program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the Health First Wellness Incentive Program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the Health First Wellness Incentive Program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the Health First Wellness Incentive Program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Barb Winey, HR Director at 330-287-5409 or bwiney@wayneohio.org.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 9-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Wayne County Benefits Administrator 330-287-5410

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The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Wayne County	34-6003005
5. Employer address	6. Employer phone number
428 W Liberty Street	330-287-5400

7. City	8. State	9. ZIP code
Wooster	OH	44691

10. Who can we contact about employee health coverage at this job?	
Wayne County Benefits Administrator	
11. Phone number (if different from above)	12. Email address
	commissioners@wayneohio.org

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☑ Some employees. Eligible employees are:

All employees who are paid an average of 30 hours per week or more and are employed full time. This applies to employees of Wayne County. Employees of different appointing authorities need to check with their supervisors for their eligibility for the benefit plan.

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

Please see our Medical Summary Plan Description for complete details on dependent coverage.

☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

THIS IS A SAMPLE! Please consult your Payroll Department to complete this page.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 368(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Summary of Benefit Coverage

Current Plan Year:

This is only a recap of Wayne County plan design: For further details about coverage and costs, please refer to the Summary Plan Description (SPD) or contact our HR Director at 330-287-5409.

IMPORTANT QUESTIONS	ANSWERS			WHY THIS MATTERS
	Low-Deductible With Incentive	**Low-Deductible Without Incentive**	**High-Deductible Consumer Driven**	
What is the overall deductible?	For each Calendar Year, In-network: Individual $500 / Family $1,000 Out-of-network: Individual $1,000 / Family $2,000	For each Calendar Year, In-network: Individual $1,000 / Family $2,000 Out-of-network: Individual $1,500 / Family $3,000	For each Calendar Year, In-network: Individual $1,800 / Family $3,600 Individual within Family $3,200 Out-of-network: Individual $1,800 / Family $3,600 Individual within Family $3,200	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes, in-network preventative charges are covered 100%	Yes, in-network preventative charges are covered 100%	Yes, in-network preventative charges are covered 100%	
Are there other deductibles for specific services?	No	No	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	In-network: Individual $1,500 / Family $3,000; Out-of-network: Individual $3,000 / Family $6,000	In-network: Individual $3,000 / Family $6,000; Out-of-network: Individual $4,500 / Family $9,000	In-network: Individual $5,000 / Family $10,000; Out-of-network: Individual $10,000 / Family $20,000	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for services	Premiums, copays, balance-billed charges, penalties for failure to obtain pre-authorization	Premiums, copays, balance-billed charges, penalties for failure to obtain pre-authorization	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

	and health care this plan doesn't cover	for services and health care this plan doesn't cover	for services and health care this plan doesn't cover	
IMPORTANT QUESTIONS	**ANSWERS**			**WHY THIS MATTERS**
	With Incentive	**Without Incentive**	**High Deductible**	
Will you pay less if you use a network provider?	Yes. For a list of in-network providers, see www.cigna.com or call 1-800-244-6224	Yes. For a list of in-network providers, see www.cigna.com or call 1-800-244-6224	Yes. For a list of in-network providers, see www.cigna.com or call 1-800-244-6224	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist	No. You don't need a referral to see a specialist	No. You don't need a referral to see a specialist	You can see the specialist you choose without permission from this plan
Are there services this plan doesn't cover?	Yes	Yes	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services

- ☐ **Copayments** are fixed dollar amounts (for example, $20) you pay for covered health care, usually when you receive the service.
- ☐ **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- ☐ The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- ☐ This plan may encourage you to use in-network providers by charging you lower deductibles, copayments, and coinsurance amounts.

Common Medical Event	**Services You May Need**	**Retail** (30-day supply)	**Mail** (90-day supply)	**Limitations & Exceptions**
If you need drugs to treat your illness or condition, more information about prescription drug coverage is available at www.cigna.com	Generic drugs	12 %	15% up to a $20 maximum	Some medications may not be covered, or you may pay more if you choose a brand name over a generic if available.
	Preferred brand drugs	30%	30% up to a $120 maximum	
	Non-preferred brand drugs	50%	50% up to a $180 maximum	*Note that this maximum amount does not include any DAW (Dispense as Written) penalty for filling a Non-Preferred brand that has a Generic available.*
	Specialty drugs	Under Prudent Rx Program, $0 copay for eligible specialty prescriptions. If you opt out of the program, 30% co-insurance charge up to your Maximum Out of Pocket for eligible specialty prescriptions,		
	Out-of-Pocket Maximum (OOP) On Low-Ded plan with incentive	$2,000 Maximum Out-of-Pocket per Individual for all drugs (Low-Ded Plan – this is separate from Medical OOP) $4,000 Maximum Out-of-Pocket per Family for all drugs (Low-Ded Plan – this is separate from Medical OOP)		
	Out-of-Pocket Maximum	$3,000 Maximum Out-of-Pocket per Individual for all drugs (Low-Ded Plan – this is separate from Medical OOP)		

	(OOP) On Low-Ded plan without incentive	$6,000 Maximum Out-of-Pocket per Family for all drugs (Low-Ded Plan – this is separate from Medical OOP) For those on the High Deductible Plan, prescription costs go towards the *Medical* Out-of-Pocket Maximum

Updated 10/7/2022

Common Medical Event	Services You May Need	Your Cost if you use an In-Network Provider			Your Cost if you use an Out-Of-Network Provider			Limitations & Exceptions
		With Incentive	Without Incentive	High Deductible	With Incentive	Without Incentive	High Deductible	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit, deductible waived	$40 copay per visit	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	Coverage is limited to 20 visits per calendar year for chiropractic care
	Specialist visit	$40 copay per visit, deductible waived	$80 copay per visit	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
	Preventive care/screening/immunization	No charge, deductible waived	No charge	No charge, deductible waived	40% coinsurance	40% coinsurance	35% coinsurance	Age and frequency schedules may apply
If you have a test	Diagnostic test (blood work)	$40 copay per visit	$80 copay per visit	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
	Imaging (CT/PET scan, MRI, x-ray)	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
	Physician/surgeon fees	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
If you need immediate medical attention	Emergency room services	$150 copay per visit	$300 copay per visit	15% coinsurance	$150 copay per visit	$300 copay per visit	35% coinsurance	No coverage for non-emergency use
	Emergency medical transportation	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
	Urgent care	$20 copay per visit	$40 copay per visit	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	Pre-authorization required for out-of-network care or $500 penalty may apply.
	Physician/surgeon fee	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
If you are pregnant	Prenatal and postnatal care	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None

	Delivery and all inpatient services	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None

Whenever you pay a co-insurance, you usually have to pay your deductible first before your co-insurance is calculated.

Updated 10/7/2022

Common Medical Event	Services You May Need	Your Cost if you use an In-Network Provider			Your Cost if you use an Out-Of-Network Provider			Limitations & Exceptions
		With Incentive	Without Incentive	High Deductible	With Incentive	Without Incentive	High Deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral Health or Substance Use Disorder Office Visits	$20 copay per visit, deductible waived	$40 copay per visit	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
	Mental/Behavioral Health or Substance Use Disorder Inpatient Services	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	Coverage is limited to 30 days per calendar year in-network and 10 days per calendar year out-of-network. Pre-authorization required for out-of-network care or $500 penalty may apply.
	Mental/Behavioral Health or Substance Use Disorder Outpatient Services	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	Coverage is limited to 50 visits per calendar year in-network and 20 visits per calendar year out-of-network.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	Coverage is limited to 30 visits per calendar year.
	Rehabilitation services	$40 copay per visit	$80 copay per visit	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	Coverage is limited to 30 visits for physical therapy and 20 visits each for occupational therapy and speech therapy.
	Habilitation services	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Services for Autism coverage is limited to 30 visits for physical therapy and 20 visits each for occupational and speech therapy.
	Skilled nursing care	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	Coverage is limited to 180 days per calendar year. Pre-authorization required for out-of-network care or $500 penalty may apply.
	Durable medical equipment	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
	Hospice service	No charge, deductible waived	No charge, deductible waived	15% coinsurance	No charge, deductible waived	No charge, deductible waived	35% coinsurance	Coverage is limited to 360 days per lifetime. Pre-authorization required for out-of-network care or $500 penalty may apply.

If your child needs dental or eye care	Eye exam							VSP, see Vision SPD
	Glasses							
	Dental check-up							Delta, see Dental SPD
Whenever you pay a co-insurance, you usually have to pay your deductible first before your co-insurance is calculated.								

Services Your Plan Does Not Cover

This isn't a complete list. Check your policy or plan document for other excluded services.

- ☐ Acupuncture
- ☐ Bariatric Surgery
- ☐ Cosmetic Surgery
- ☐ Dental Care (Adult)
- ☐ Dental Care (Child)
- ☐ Glasses (Child)
- ☐ Habilitation Services
- ☐ Long-Term Care
- ☐ Private-Duty Nursing
- ☐ Routine Eye Care (Adult)
- ☐ Routine Eye Care (Child)
- ☐ Routine Foot Care
- ☐ Weight Loss Programs

Other Covered Services

This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.

- ☐ Chiropractic Care (limited to 20 visits per calendar year)
- ☐ Hearing Aids (limited to $2,000 over a 3 year period)
- ☐ Infertility Treatment (diagnosis & treatment of underlying medical condition only)
- ☐ Non-Emergency Care when traveling outside the U.S.

Your Rights to Continue Coverage

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-244-6224. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights

- ☐ **Medical/Prescription:** If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Cigna at 1-800-244-6224, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), www.dol.gov/ebsa/healthreform; or Wayne County HR Director, 330-287-5409. Additionally, Cigna's website can give you steps to file an appeal. Information is at https://www.cigna.com/health-care-providers/coverage-and-claims/appeals-disputes/how-to-submit.
- ☐ **Dental:** If you receive notice of an Adverse Benefit Determination and you think that Delta Dental incorrectly denied all or part of your Claim, you or your Dentist may contact Delta Dental's Customer Service department and ask them to reconsider the Claim to make sure it was processed correctly. You may do this by calling the toll-free number, 800-524-0149, and speaking to a telephone advisor. For further and more detailed information on this process, please refer to the *Claims Appeal Procedure* on page 21 behind Tab 4.

Does this plan provide Minimum Essential Coverage?

- ✔ **Yes.**

Does this plan meet the Minimum Value Standards?

- ✔ **Yes.**

Coverage Examples

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans. Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be difference from these examples, and the cost of that care will also be different. See the next page for important information about these examples. **These are examples only and not reflective of our actual plan.**

Having a baby (9 months of in-network pre-natal care and a hospital delivery)				**Managing Type 2 diabetes** (in-network routine maintenance of a well-controlled condition)				**Simple Fracture** (in-network emergency room visit and follow up care)			
Plan's Overall Deductible	$500	$1,000	$1,800	**Plan's Overall Deductible**	$500	$1,000	$1,800	**Plan's Overall Deductible**	$500	$1,000	$1,800
Specialist Visit	$40 copay	$80 copay	85% covered*	**Primary Care Visit**	$20 copay	$40 copay	85% covered*	**Specialist Visit**	$40 copay	$80 copay	85% covered*
Hospital (facility) *After Deductible	80% covered*	70% covered*	85% covered*	**Hospital (facility)**	80% covered*	70% covered*	85% covered*	**Hospital (facility)**	80% covered*	70% covered*	85% covered*
Specialist office visits (prenatal care)				Primary care physician (office visits)	$500.00 (5)	$500.00 (5)	$500.00 (5)	Emergency Room Visit	$1,200.00	$1,200.00	$1,200.00
Childbirth/ delivery Professional Services	$1,857.15	$1,857.15	$1,857.15	Diagnostic Tests (blood work)	$1,200.00	$1,200.00	$1,200.00	Diagnostic Test (x-ray)	$500.00	$500.00	$500.00
Childbirth/ delivery Facility Services	$8,142.85	$8,142.85	$8,142.85	Prescription Drugs	$1,800.00	$1,800.00	$1,800.00	Durable medical equipment (crutches)	$500.00	$500.00	$500.00
Diagnostic Tests (ultrasounds and bloodwork)	$1,500.00	$1,500.00	$1,500.00	Durable medical equipment (glucose meter)	$2,100.00	$2,100.00	$2,100.00	Rehabilitation services (physical therapy)	$600.00 (6)	$600.00 (6)	$600.00 (6)
Specialist visit (anesthesia)	$1,180.00	$1,180.00	$1,180.00	Vaccines, other preventive	0	0	0				
Total owed to providers	**$12,680**	**$12,680**	**$12,680**	**Total owed to providers**	**$5,600**	**$5,600**	**$5,600**	**Total owed to providers**	**$2,800**	**$2,800**	**$2,800**
Patient pays:	Low-Ded **With Incentive**	Low-Ded **Without Incentive**	**High-Ded**	**Patient pays:**	Low-Ded **With Incentive**	Low-Ded **Without Incentive**	**High-Ded**	**Patient pays:**	Low-Ded **With Incentive**	Low-Ded **Without Incentive**	**High-Ded**
Deductibles	$500.00	$1,000.00	$1,800.00	Deductibles	$500.00	$1,000.00	$1,800.00	Deductibles	$500.00	$1,000.00	$1,800.00
Copays	$0.00	$0.00	n/a	Copays	$100.00	$200.00	n/a	Copays	$390.00	$780.00	N/A
Coinsurance	$1,000.00	$2,000.00	$1,632.00	Coinsurance	$900.00	$1,320.00	$570.00	Coinsurance	$100.00	$0.00	$150.00
Limits or exclusions (not covered)	n/a	n/a	n/a	Limits or exclusions (not covered)	n/a	n/a	n/a	Limits or exclusions (not covered)	n/a	n/a	n/a
Maximum out of pocket met?	YES	YES	NO	Maximum out of pocket met?	YES	NO	NO	Maximum out of pocket met?	NO	NO	NO
Total Patient pays	**$1,500**	**$3,000**	**$3,432**	**Total Patient pays**	**$1,500**	**$2,520**	**$2,370**	**Total Patient Pays**	**$990**	**$1,780**	**$1,950**
Total Plan pays	**$11,180**	**$9,700**	**$9,248**	**Total Plan pays**	**$4,400**	**$3,640**	**$3,230**	**Total Plan Pays**	**$1,810**	**$1,020**	**$850**

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Questions and Answers about the Coverage Examples

What are some of the assumptions behind the Coverage Examples?

- ☐ Costs don't include premiums
- ☐ Sample care costs are based on national averages supplies by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- ☐ The patient's condition was not an excluded or preexisting condition.
- ☐ All services and treatments started and ended in the same coverage period.
- ☐ There are no other medical expenses for any member covered under this plan.
- ☐ Out-of-pocket expenses are based only on treating the condition in the example.
- ☐ The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.