



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <http://BeWell.franklincountyohio.gov> or by calling 1-877-440-5983.

Important Questions	Answers	Why This Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>Network: \$200 Individual / \$500 Family Non-Network: \$400 Individual / \$1,000 Family Per policy year. Copays, prescription drugs, and services listed below as "No Charge" do not apply to the <u>deductible</u>.</p>	<p>You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your summary plan description or plan document to see when the <u>deductible</u> 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 <u>deductible</u>.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>A \$1,700 deductible applies to morbid obesity surgery. A \$1,000 deductible applies to skin excision.</p>	<p>You must pay all the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.</p>
<p>Is there an <u>out-of-pocket limit</u> on my expenses?</p>	<p>Network: \$600 Individual / \$1,500 Family Non-Network: \$1,200 Individual / \$3,000 Family</p>	<p>The <u>out-of-pocket limit</u> 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.</p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p><u>Premium</u>, balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain prior notification for services.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Is there an overall annual limit on what the plan pays?</p>	<p>No.</p>	<p>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</p>
<p>Does this plan use a <u>network of providers</u>?</p>	<p>Yes. For a list of <u>network providers</u>, see myuhc.com or call 1-877-440-5983.</p>	<p>If you use an in-network doctor or other health care <u>provider</u>, 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u>, or participating for <u>providers</u> in their <u>network</u>. See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u>.</p>
<p>Do I need a referral to see a <u>specialist</u>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without permission from this plan.</p>
<p>Are there services this plan doesn't cover?</p>	<p>Yes.</p>	<p>Some of the services this plan doesn't cover are listed on page 5. See your summary plan description or plan document for additional information about <u>excluded services</u>.</p>

Questions: Call 1-877-440-5983 or visit us at <http://BeWell.franklincountyohio.gov>. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) 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 a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-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 network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic Please refer to www.myuhc.com for details regarding UnitedHealth Premium program.	Primary care visit to treat an injury or illness	\$20 copay per visit	20% co-ins after deductible.	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. Pre-authorization is required non-network for genetic testing – BRCA (Breast Cancer gene test) or benefit reduces to 50% of eligible expenses.
	Specialist visit	\$20 or \$40 copay per visit depending on provider's Tier 1 status.	20% co-ins after deductible.	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. Pre-authorization is required non-network for genetic testing – BRCA (Breast Cancer gene test) or benefit reduces to 50% of eligible expenses.
	Other practitioner office visit	\$20 copay per visit	20% co-ins after deductible.	Cost share applies to manipulative (chiropractic) services only and is limited to 25 visits per policy year.
	Preventive care / screening / immunization	No Charge	20% co-ins after deductible.	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% co-ins after deductible.	None
	Imaging (CT / PET scans, MRIs)	0% co-ins after deductible.	20% co-ins after deductible.	None

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.optum.com or by calling 1-855-312-2309.</p>	Tier 1 –Generic drugs	Retail: \$5 copay Mail-Order: \$12.50	Retail: \$5 copay Mail-Order: N/A	<p>Provider means pharmacy for purposes of this section. Retail: Up to a 30 day supply Mail-Order: Up to a 90 day supply You may need to obtain certain drugs from a pharmacy designated by us. If you use a non-network pharmacy you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to certain prescribed drugs. Not all drugs are covered. Out of Pocket limit: \$5,333 Individual / \$13,333 Family. Certain preventive medications are covered at No Charge. No coverage for prescription drugs with UnitedHealthcare. <i>If a Non-Preferred brand drug is available as a Generic drug, and the Non-Preferred brand drug is chosen over its Generic, an additional ancillary fee is charged.</i></p>
	Tier 2 –Preferred brand name drugs	Retail: \$25 copay Mail-Order: \$62.50	Retail: \$25 copay Mail-Order: N/A	
	Tier 3 –Non-preferred Non-formulary drugs	Retail: \$50 copay Mail Order: \$125 copay	Retail: \$50 copay Mail Order: N/A	
	<p>Tier 4 – Specialty drugs</p> <p>All Specialty drugs must be obtained through the Designated Specialty Pharmacy.</p>	<p>Retail 30-day supply: Generic: \$5 copay Preferred: \$25 copay Specialty: \$50 copay Mail-Order 90-day supply: Generic: \$12.50 copay Preferred: \$62.50 copay Specialty: 10% up to \$300 copay</p>	Not Covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	0% co-ins after deductible.	20% co-ins after deductible.	None
	Physician / surgeon fees	0% co-ins after deductible.	20% co-ins after deductible.	None
<p>If you need immediate medical attention</p>	Emergency room services	\$150 copay per visit	\$150 copay per visit	Copayment is waived if patient is admitted directly to hospital from emergency room.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	\$25 copay per visit	20% co-ins after deductible.	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.



Franklin County Elected Officials Post-April 2011 Choice Plus Plan

Coverage Period: 04/01/2016 – 12/31/2016

Summary of Benefits and Coverage: What This Plan Covers & What it Costs Coverage for: Employee & Family Plan Type: PS1

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-ins after deductible.	20% co-ins after deductible.	Pre-notification is required for non-network facility or benefit reduces to 50% of eligible expenses.
	Physician / surgeon fees	0% co-ins after deductible.	20% co-ins after deductible.	None
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	No copay for first 30 visits	20% co-ins after deductible.	\$20 copay per visit after first 30 visits.
	Mental / Behavioral health inpatient services	No Charge	20% co-ins after deductible.	See pre-notification language under hospital stay.
	Substance use disorder outpatient services	No copay for first 30 visits	20% co-ins after deductible.	\$20 copay per visit after first 30 visits.
	Substance use disorder inpatient services	No Charge	20% co-ins after deductible.	See pre-notification language under hospital stay.
If you are pregnant	Prenatal and postnatal care	\$20 copay, initial visit	20% co-ins after deductible.	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	0% co-ins after deductible.	20% co-ins after deductible.	Inpatient pre-notification is required. Your cost for inpatient services only. Delivery Services cost share is reflected in "Physician/surgeon fees" above.
If you need help recovering or have other special health needs	Home health care	0% co-ins after deductible.	20% co-ins after deductible.	Limited to 120 visits per policy year. See pre-notification language under hospital stay.
	Rehabilitation services	\$20 copay per outpatient visit	20% co-ins after deductible.	Limits per policy year: physical, speech, occupational, cardiac, pulmonary – 25 visits each. See pre-notification language under hospital stay.
	Habilitative services	\$20 copay per outpatient visit	20% co-ins after deductible.	Limits are combined with Rehabilitation Services limits listed above.
	Skilled nursing care	0% co-ins after deductible.	20% co-ins after deductible.	Nursing limited to 100 days per policy year. Inpatient rehabilitation services are limited to 45 days per policy year. See pre-notification language under hospital stay.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Durable medical equipment	0% co-ins after deductible.	20% co-ins after deductible.	Pre-notification is required for non-network for DME over \$1,000. Covers 1 per type of DME (including repair/replacement) every 3 years.
	Hospice service	No Charge	20% co-ins after deductible.	Inpatient pre-notification is required for non-network or benefit reduces to 50% of eligible expenses.
If your child needs dental or eye care	Eye exam	\$20 copay per outpatient visit	20% co-ins after deductible.	None
	Glasses	Not Covered	Not Covered	No coverage for glasses. Full vision benefits available under vision plan.
	Dental check-up	Not Covered	Not Covered	No coverage for dental check-up. Full dental coverage available under dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your summary plan description or plan document for other <u>excluded services</u> .)			
<ul style="list-style-type: none"> Acupuncture Cosmetic surgery 	<ul style="list-style-type: none"> Glasses (Adult/Child) Infertility treatment Long-term care 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. Private-duty nursing 	<ul style="list-style-type: none"> Routine foot care Weight loss programs
Other Covered Services (This isn't a complete list. Check your summary plan description or plan document for other covered services and your costs for these services.)			
<ul style="list-style-type: none"> Bariatric surgery Chiropractic care 	<ul style="list-style-type: none"> Dental care (Adult/Child) Hearing aids 	<ul style="list-style-type: none"> Routine eye care (Adult/Child) 	<ul style="list-style-type: none"> Nutritional counseling Gender Identity Disorder

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.



Franklin County Elected Officials Post-April 2011 Choice Plus Plan

Coverage Period: 04/01/2016 – 12/31/2016

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for:** Employee & Family **Plan Type:** PS1

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. 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:

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 the Member Service number listed on the back of your ID card or www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-440-5983.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-877-440-5983.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-877-440-5983.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-440-5983.

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

Coverage Examples

About these 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.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Coverage for: Employee & Family Plan Type: PS1

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,310
- Patient pays \$230

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40

Total \$7,540

Patient pays:

Deductibles	\$0
Copays	\$30
Coinsurance	\$0
Limits or exclusions	\$200

Total \$230

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,720
- Patient pays \$680

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100

Total \$5,400

Patient pays:

Deductibles	\$200
Copays	\$400
Coinsurance	\$0
Limits or exclusions	\$80

Total \$680

Questions and answers about Coverage Examples:

<p>What are some of the assumptions behind the Coverage Examples?</p> <ul style="list-style-type: none"> • Costs don't include premiums. • Sample care costs are based on national averages supplied to 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 deductible or preexisting condition. • All services and treatments started and ended deductible 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. • If other than individual coverage, the Patient Pays amount may be more. 	<p>What does a Coverage Example show?</p> <p>For each treatment situation, the Coverage Example helps you see how deductible, 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.</p>	<p>Can I use Coverage Examples to compare plans?</p> <p>✓ 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.</p>
	<p>Does the Coverage Example predict my own care needs?</p> <p>✗ 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.</p>	<p>Are there other costs I should consider when comparing plans?</p> <p>✓ 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, deductible, 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.</p>
	<p>Does the Coverage Example predict my future expenses?</p> <p>✗ 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.</p>	

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