OhioHealth **OhioHealth Corporation: Core PPO Plan** **Coverage for: Individual, Individual + 1, Family | Plan Type: PPO**

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, go to www.OhioHealthyPlans.com. 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 1-833-865-1190 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 preferred provider: $950/individual, $1,425/individual + 1, $1,900/family, per benefit period. Tier 2 preferred provider: $2,000/individual, $2,500/individual + 1, $4,000/family, per benefit period. Tier 3 nonpreferred provider: $4,500/individual, $6,750/individual + 1, $9,000/family, per benefit period.	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. Prescription drugs and the following services by a Tier 1 or Tier 2 provider: preventive care services, office services, urgent care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Prescription drug deductible. $150/individual, $300/individual + 1, $450/family, per benefit period. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Tier 1 preferred provider: $3,000/individual, $4,500/individual + 1, $6,000/family, per benefit period. Tier 2 preferred provider: $5,000/individual, $7,500/individual + 1, $10,000/family, per benefit period. Tier 3 nonpreferred provider: Unlimited.	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?	Penalties for failure to obtain preauthorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.OhioHealthyPlans.com or call 1-833-865-1190 for a list of network providers.	You pay the least if you use a Tier 1 preferred providers in the OhioHealthy Preferred network. You pay more if you use a Tier 2 preferred provider in the OhioHealthy Preferred network or the Aetna wrap network. You will pay the most if you use a Tier 3 (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 a referral.

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
		Tier 1 Preferred Provider (You will pay the least)	Tier 2 Preferred Provider (You will pay less)	Tier 3 Nonpreferred 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	$20 copay/visit deductible does not apply	$35 copay/visit deductible does not apply	50% coinsurance	None
	Specialist visit	$35 copay/visit deductible does not apply	$75 copay/visit deductible does not apply	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	50% coinsurance	Preauthorization is required for PET, MRA and CTA. If you don't get preauthorization, benefits could be denied.

* For more information about limitations and exceptions, see the plan or policy document at www.OhioHealthyPlans.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Preferred Provider (You will pay the least)	Tier 2 Preferred Provider (You will pay less)	Tier 3 Nonpreferred 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.navitus.com or call 1-855-673-6504.	Preferred Generic drugs (Tier 1)	30-day supply: $10 copay after prescription drug deductible. Plan deductible does not apply. 31-90 day supply: $25 copay after prescription drug deductible. Plan deductible does not apply.		Not covered	Preferred brand and non-preferred brand (& some generic drugs) Retail and Mail-Order prescriptions limited to a 90-day supply. Specialty drugs limited to a 30-day supply. Copay, coinsurance and deductibles do not apply to preventive drugs required by the Affordable Care Act. If you purchase a brand name drug when a generic drug is available, you must pay difference in cost plus the coinsurance amount. Fertility drugs are subject to 40% coinsurance and limited to a lifetime combined medical and pharmacy maximum benefit of $12,000. Preauthorization, step therapy and quantity limits are required as indicated on the pharmacy benefit prescription drug list. Preauthorization required by Archimedes for all specialty drugs dispensed through the medical benefit and administered in a facility or by a professional provider listed under the URL https://www.ohiohealthyplans.com/providers/pharmacy. Archimedes can be contacted by calling the phone number for pre-certification found on the back of the ID card.
	Preferred brand & some generic drugs (Tier 2)	25% coinsurance deductibles do not apply	25% coinsurance deductibles do not apply	Not covered	
	Non-preferred brand drugs & some generic drugs (Tier 3)	30% coinsurance deductibles do not apply	30% coinsurance deductibles do not apply	Not covered	
	Specialty drugs	25% coinsurance up to $500 maximum copayment		Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Preferred Provider (You will pay the least)	Tier 2 Preferred Provider (You will pay less)	Tier 3 Nonpreferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital: $300 copay then 20% coinsurance Ambulatory: 20% coinsurance	Hospital: $500 copay then 30% coinsurance Ambulatory: $50 copay then 30% coinsurance	50% coinsurance	Preauthorization is required for some surgeries. If you don't get preauthorization, benefits could be denied.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$300 copay then 10% coinsurance after deductible	Tier 1 provider benefit applies	Tier 1 provider benefit applies	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	Tier 1 provider benefit applies	Tier 1 provider benefit applies	None
	Urgent care	$35 copay/visit deductible does not apply	$75 copay/visit deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be denied.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit deductible does not apply and 20% coinsurance for other outpatient services	Tier 1 provider benefit applies	50% coinsurance	Preauthorization is required for some outpatient services. If you don't get preauthorization, benefits could be denied.
	Inpatient services	20% coinsurance	Tier 1 provider benefit applies	50% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be denied.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Preferred Provider (You will pay the least)	Tier 2 Preferred Provider (You will pay less)	Tier 3 Nonpreferred Provider (You will pay the most)	
If you are pregnant	Office visits	$20/$35 copay/visit deductible does not apply	$35/$75 copay/visit deductible does not apply	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be denied.
	Rehabilitation services	20% coinsurance	30% coinsurance	50% coinsurance	50 visits/benefit period combined for physical therapy, speech therapy, and occupational therapy.
	Habilitation services	20% coinsurance	30% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	30% coinsurance	50% coinsurance	120 day/benefit period. Preauthorization is required. If you don't get preauthorization, benefits could be denied.
	Durable medical equipment	20% coinsurance	Tier 1 provider benefit applies	50% coinsurance	Preauthorization is required for single items over $1,500, all rental items, repairs and replacements. If you don't get preauthorization, benefits could be denied.
	Hospice services	20% coinsurance	30% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be denied.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	No charge	Limit one per benefit period.
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

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.)

- Cosmetic surgery
- Dental care
- Hearing aids
- Infertility treatment (provided through Maven Clinic-contact benefits@mavenclinic.com)
- Long-term care
- Private-duty nursing
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture, limited to treatment of back pain and migraines, limited to 15 visits per benefit period. Preauthorization is required.
- Bariatric surgery. Preauthorization is required.
- Chiropractic care, limited to 20 visits per benefit period
- Non-emergency care when traveling outside the U.S.
- Routine eye care, limited to one exam per benefit period
- Weight loss programs, limited to OhioHealth Medical Treatment Program facilities

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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 on how 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-833-865-1190.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-833-865-1190.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-865-1190.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-833-865-1190 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-865-1190.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-833-865-1190.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-833-865-1190.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-833-865-1190.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$950**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$950
Copayments	$0
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$950**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,100
Copayments	$400
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$950**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

The plan would be responsible for the other costs of these EXAMPLE covered services.