




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: |
|---|--|--|
| <p>What is the overall deductible?</p> | <p>Tier 1 preferred provider: \$450/individual, \$675/individual + 1, \$900/family, per benefit period.</p> <p>Tier 2 preferred provider: \$1,500/individual, \$2,250/individual + 1, \$3,000/family, per benefit period.</p> <p>Tier 3 nonpreferred provider: \$3,000/individual, \$4,500/individual + 1, \$6,000/family, per benefit period.</p> | <p>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.</p> <p>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.</p> |
| <p>Are there services covered before you meet your deductible?</p> | <p>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.</p> | <p>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/.</p> |
| <p>Are there other deductibles for specific services?</p> | <p>Yes. Generic (Tier 1) prescription drug deductible. \$100/individual, \$200/individual + 1, \$300/family, per benefit period. There are no other specific deductibles.</p> | <p>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.</p> |
| <p>What is the out-of-pocket limit for this plan?</p> | <p>Tier 1 preferred provider: \$2,500/individual, \$3,750/individual + 1, \$5,000/family, per benefit period.</p> <p>Tier 2 preferred provider: \$5,000/individual, \$7,500/individual + 1, \$10,000/family, per benefit period.</p> <p>Tier 3 nonpreferred provider: Unlimited.</p> | <p>The out-of-pocket limit is the most you could pay in a year for covered services.</p> <p>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.</p> |
| <p>What is not included in the out-of-pocket limit?</p> | <p>Penalties for failure to obtain preauthorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.</p> | <p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p> |

| 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 | \$10 copay /visit deductible does not apply | \$35 copay /visit deductible does not apply | 50% coinsurance | None |
| | Specialist visit | \$25 copay /visit deductible does not apply | \$50 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) | 10% coinsurance | 30% coinsurance | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 10% 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) | |
| <p>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.</p> | Preferred Generic drugs (Tier 1) | 30-day supply: \$10 copay after prescription drug deductible . Plan deductible does not apply. 31-90 day supply: \$20 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. |
| | Preferred brand & some generic drugs (Tier 2) | 20% coinsurance deductibles do not apply | 20% coinsurance deductibles do not apply | Not covered | 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. |
| | Non-preferred brand drugs & some generic drugs (Tier 3) | 30% coinsurance deductibles do not apply | 30% coinsurance deductibles do not apply | Not covered | 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 . |
| | Specialty drugs | 20% coinsurance up to \$500 maximum copayment | | Not covered | Archimedes can be contacted by calling the phone number for pre-certification found on the back of the ID card. |

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| 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 10% coinsurance Ambulatory: 10% 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 | 10% 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 | 10% coinsurance | Tier 1 provider benefit applies | Tier 1 provider benefit applies | None |
| | Urgent care | \$35 copay /visit deductible does not apply | \$55 copay /visit deductible does not apply | 50% coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | 50% coinsurance | Preauthorization is required. If you don't get preauthorization , benefits could be denied. |
| | Physician/surgeon fees | 10% 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 10% 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 | 10% coinsurance | Tier 1 provider benefit applies | 50% coinsurance | Preauthorization is required. If you don't get preauthorization , benefits could be denied. |

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| 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 | \$10/\$25 copay /visit deductible does not apply | \$35/\$50 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 | 10% coinsurance | 30% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 10% coinsurance | 30% coinsurance | 50% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 10% coinsurance | 30% coinsurance | 50% coinsurance | Preauthorization is required. If you don't get preauthorization , benefits could be denied. |
| | Rehabilitation services | 10% coinsurance | 30% coinsurance | 50% coinsurance | 50 visits/benefit period combined for physical therapy, speech therapy, and occupational therapy. |
| | Habilitation services | 10% coinsurance | 30% coinsurance | 50% coinsurance | |
| | Skilled nursing care | 10% 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 | 10% 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 | 10% 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 |

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

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): 如果需要中文的帮助, 请拨打这个号码 1-833-865-1190.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo 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, a'gang 1-833-865-1190.

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

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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](#) \$450
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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:

| | |
|---------------------|--|
| <i>Cost Sharing</i> | |
|---------------------|--|

| | |
|-----------------------------|---------|
| Deductibles | \$500 |
| Copayments | \$0 |
| Coinsurance | \$1,200 |

| | |
|---------------------------|--|
| <i>What isn't covered</i> | |
|---------------------------|--|

| | |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

| | |
|-----------------------------------|----------------|
| The total Peg would pay is | \$1,760 |
|-----------------------------------|----------------|

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$450
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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:

| | |
|---------------------|--|
| <i>Cost Sharing</i> | |
|---------------------|--|

| | |
|-----------------------------|-------|
| Deductibles | \$550 |
| Copayments | \$300 |
| Coinsurance | \$700 |

| | |
|---------------------------|--|
| <i>What isn't covered</i> | |
|---------------------------|--|

| | |
|----------------------|------|
| Limits or exclusions | \$20 |
|----------------------|------|

| | |
|-----------------------------------|----------------|
| The total Joe would pay is | \$1,570 |
|-----------------------------------|----------------|

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$450
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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:

| | |
|---------------------|--|
| <i>Cost Sharing</i> | |
|---------------------|--|

| | |
|-----------------------------|-------|
| Deductibles | \$500 |
| Copayments | \$400 |
| Coinsurance | \$200 |

| | |
|---------------------------|--|
| <i>What isn't covered</i> | |
|---------------------------|--|

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|----------------|
| The total Mia would pay is | \$1,100 |
|-----------------------------------|----------------|

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.