



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](http://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:
<b>What is the overall <a href="#">deductible</a>?</b>	Tier 1 <a href="#">preferred provider</a> : \$950/individual, \$1,425/individual + 1, \$1,900/family, per benefit period. Tier 2 <a href="#">preferred provider</a> : \$2,000/individual, \$2,500/individual + 1, \$4,000/family, per benefit period. Tier 3 <a href="#">nonpreferred provider</a> : \$4,500/individual, \$6,750/individual + 1, \$9,000/family, per benefit period.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Prescription drugs and the following services by a Tier 1 or Tier 2 <a href="#">provider</a> : <a href="#">preventive care</a> services, office services, <a href="#">urgent care</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. <a href="#">Prescription drug deductible</a> . \$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 <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Tier 1 <a href="#">preferred provider</a> : \$3,000/individual, \$4,500/individual + 1, \$6,000/family, per benefit period. Tier 2 <a href="#">preferred provider</a> : \$5,000/individual, \$7,500/individual + 1, \$10,000/family, per benefit period. Tier 3 <a href="#">nonpreferred provider</a> : Unlimited.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met. If you have other family members in this plan, the overall family <a href="#">out-of-pocket limit</a> must be met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Penalties for failure to obtain <a href="#">preauthorization</a> for services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.OhioHealthyPlans.com">www.OhioHealthyPlans.com</a> or call 1-833-865-1190 for a list of <a href="#">network providers</a> .	You pay the least if you use a Tier 1 <a href="#">preferred providers</a> in the OhioHealthy Preferred network. You pay more if you use a Tier 2 <a href="#">preferred provider</a> in the OhioHealthy Preferred network or the Aetna wrap network. You will pay the most if you use a Tier 3 ( <a href="#">out-of-network provider</a> ), and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance-billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's office</a> or <a href="#">clinic</a>	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	\$35 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$35 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	\$75 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for PET, MRA and CTA. If you don't get <a href="#">preauthorization</a> , 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)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.navitus.com">www.navitus.com</a> or call 1-855-673-6504.</p>	Preferred Generic drugs (Tier 1)	30-day supply: \$10 <a href="#">copay</a> after <a href="#">prescription drug deductible</a> . <a href="#">Plan deductible</a> does not apply. 31-90 day supply: \$25 <a href="#">copay</a> after <a href="#">prescription drug deductible</a> . <a href="#">Plan deductible</a> 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. <a href="#">Specialty drugs</a> limited to a 30-day supply. <a href="#">Copay</a> , <a href="#">coinsurance</a> and <a href="#">deductibles</a> do not apply to preventive drugs required by the Affordable Care Act.
	Preferred brand & some generic drugs (Tier 2)	25% <a href="#">coinsurance deductibles</a> do not apply	25% <a href="#">coinsurance deductibles</a> 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 <a href="#">coinsurance</a> amount. Fertility drugs are subject to 40% <a href="#">coinsurance</a> and limited to a lifetime combined medical and pharmacy maximum benefit of \$12,000.
	Non-preferred brand drugs & some generic drugs (Tier 3)	30% <a href="#">coinsurance deductibles</a> do not apply	30% <a href="#">coinsurance deductibles</a> do not apply	Not covered	<a href="#">Preauthorization</a> , step therapy and quantity limits are required as indicated on the pharmacy benefit prescription drug list. <a href="#">Preauthorization</a> required by Archimedes for all <a href="#">specialty drugs</a> dispensed through the medical benefit and administered in a facility or by a professional provider listed under the URL <a href="https://www.ohiohealthyplans.com/providers/pharmacy">https://www.ohiohealthyplans.com/providers/pharmacy</a> .
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a> up to \$500 maximum <a href="#">copayment deductibles</a> do not apply	20% <a href="#">coinsurance</a> up to \$500 maximum <a href="#">copayment deductibles</a> do not apply	Not covered	Archimedes can be contacted by calling the phone number for pre-certification found on the back of the ID card.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.OhioHealthyPlans.com](http://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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital: \$300 <a href="#">copay</a> then 20% <a href="#">coinsurance</a> ; Ambulatory: 20% <a href="#">coinsurance</a>	Hospital: \$500 <a href="#">copay</a> then 30% <a href="#">coinsurance</a> ; Ambulatory: \$50 <a href="#">copay</a> then 30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for some surgeries. If you don't get <a href="#">preauthorization</a> , benefits could be denied.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$300 <a href="#">copay</a> then 10% <a href="#">coinsurance</a>	Tier 1 <a href="#">provider</a> benefit applies	Tier 1 <a href="#">provider</a> benefit applies	<a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	Tier 1 <a href="#">provider</a> benefit applies	Tier 1 <a href="#">provider</a> benefit applies	None
	<a href="#">Urgent care</a>	\$35 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	\$75 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be denied.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply and 10% <a href="#">coinsurance</a> for other outpatient services	Tier 1 <a href="#">provider</a> benefit applies	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for some outpatient services. If you don't get <a href="#">preauthorization</a> , benefits could be denied.
	Inpatient services	20% <a href="#">coinsurance</a>	Tier 1 <a href="#">provider</a> benefit applies	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be denied.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.OhioHealthyPlans.com](http://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 are pregnant	Office visits	\$20/\$35 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	\$35/\$75 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be denied.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50 visits/benefit period combined for physical therapy, speech therapy, and occupational therapy.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	120 day/benefit period. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be denied.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Tier 1 <a href="#">provider</a> benefit applies	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for single items over \$1,500, all rental items, repairs and replacements. If you don't get <a href="#">preauthorization</a> , benefits could be denied.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , 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](http://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](mailto: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](http://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](http://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](http://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](#) \$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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$950
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,100

<i>What isn't covered</i>	
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Limits or exclusions	\$60
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<b>The total Peg would pay is</b>	<b>\$3,060</b>
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### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$1,100
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$800

<i>What isn't covered</i>	
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Limits or exclusions	\$20
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<b>The total Joe would pay is</b>	<b>\$2,320</b>
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### 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$200

<i>What isn't covered</i>	
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Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$1,600</b>
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.