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, call 1-800-624-6961. 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 1-800-624-6961 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$4,000 / individual or $8,000 / family	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. Preventive care services 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$8,700 individual / $17,400 family	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?	Copayments on certain 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.
Will you pay less if you use a network provider?	Yes. See www.healthplan.org or call 1-800-624-6961 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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
		Network Provider (You will pay the least)	Out-of-Network 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	40% coinsurance	Not covered	None
	Specialist visit	40% coinsurance	Not covered	None, Preauthorization is required.
	Preventive care/screening/ immunization	No charge	Not covered	Deductible does not apply. 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)	40% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not covered	Preauthorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthplan.org.	Generic drugs	40% coinsurance (retail & mail order)	Not covered	Covers up to a 31-day supply (retail); 90 day supply (mail order)
	Preferred brand drugs	40% coinsurance (retail & mail order)	Not covered	Covers up to a 31-day supply (retail); 90 day supply (mail order). Member is responsible for cost difference between generic and preferred brand.
	Non-preferred brand drugs	40% coinsurance (retail & mail order)	Not covered	Covers up to a 31-day supply (retail); 90 day supply (mail order). Member is responsible for cost difference between generic and non-preferred brand.
	Specialty drugs	50% coinsurance	Not covered	Covers up to a 30-day supply (retail or home delivery). Preauthorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not covered	Preauthorization is required.
	Physician/surgeon fees	40% coinsurance	Not covered	Preauthorization is required.
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	True emergency services only.
	Emergency medical transportation	40% coinsurance	40% coinsurance	Non-emergency transports, preauthorization is required.
	Urgent care	40% coinsurance	40% coinsurance	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance /admission	Not covered	Preauthorization is required unless emergent admission.
	Physician/surgeon fees	40% coinsurance	Not covered	Preauthorization is required unless emergent admission.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% coinsurance	Not covered	Other care may include tests and services described elsewhere in SBC (i.e. Diagnostic Testing)
	Inpatient services	40% coinsurance	Not covered	Preauthorization is required unless emergent admission.
If you are pregnant	Office visits	40% coinsurance	Not covered	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	40% coinsurance	Not covered	None
	Childbirth/delivery facility services	40% coinsurance	Not covered	None
If you need help recovering or have other special health needs	Home health care	40% coinsurance	Not covered	100 visits/year. Preauthorization is required.
	Rehabilitation services	40% coinsurance	Not covered	20 visits/year. Includes physical, speech, and occupational therapy. Preauthorization is required.
	Habilitation services	40% coinsurance	Not covered	20 visits/year. Includes physical, speech, and occupational therapy. Preauthorization is required.
	Skilled nursing care	40% coinsurance	Not covered	90 visits/contract year. Preauthorization is required.
	Durable medical equipment	40% coinsurance	Not covered	Preauthorization is required for equipment greater than $500.
	Hospice services	40% coinsurance	Not covered	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Coverage limited to one exam/year.
	Children's glasses	No charge	Not covered	Coverage limited to one pair of glasses/year.
	Children's dental check-up	No charge	Not covered	1 exam / 6 months.

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

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- Private-duty nursing

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 are: Ohio Department of Insurance, Consumer Services Division, 1-800-686-1526 or www.insurance.ohio.gov or The Department of Health and Human Services at 1877-267-2323 x61565 or www.cciio.cms.gov. 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. For more information about your rights, this notice, or assistance, contact: The Health Plan Appeals Coordinator at 1-800-624-6961 or TTY 711. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan.

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 1-855-577-7123.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-577-7123

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-855-577-7123

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-577-7123

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	**$4,000**
Specialist copayment	**40%**
Hospital (facility) coinsurance	**40%**
Other coinsurance	**40%**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$0
Coinsurance	$3,520
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,520**

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

The plan's overall deductible	**$4,000**
Specialist copayment	**40%**
Hospital (facility) coinsurance	**40%**
Other coinsurance	**40%**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$4,000
Copayments	$0
Coinsurance	$1,360
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$5,360**

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

The plan's overall deductible	**$4,000**
Specialist copayment	**40%**
Hospital (facility) coinsurance	**40%**
Other coinsurance	**40%**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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