




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, contact MedBen's Customer Service Department at 1-800-686-8425 or mbaccess.medben.com (select MedBen Access). 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 1-877-267-2323 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$1,700 for employee only coverage and \$3,400 if family coverage for in- <u>network</u> and out-of- <u>network</u> . Per calendar year.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> services (in- <u>network</u>) are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$1,000 for employee only coverage and \$3,000 if family coverage in- <u>network</u> and out-of- <u>network</u> (coinsurance only). There is an overall <u>out-of-pocket maximum</u> of \$7,150 for an individual and \$14,300 for family (includes all applicable expenses. All per calendar year).	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, <u>deductible</u> and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See www.frontpathcoalition.com or call 1-888-2325800; www.ohiohealthchoice.com/nwohp or 1-888-232-5800; or www.myfirsthealth.com or 1-800-226-5116 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 ?	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
		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	20% coinsurance	40% coinsurance	None.
	Specialist visit	20% coinsurance	40% coinsurance	None.
	Preventive care/screening/immunization	No charge	40% 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. Colonoscopy, prostate exam and colorectal screenings limited to age 45+ and 1 per calendar year maximum, routine hearing exam limited to 1 per calendar year, mammogram age 35-39 1 every two years and age 40+ 1 per calendar year maximum and pap smear 1 per calendar year maximum.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None.

* For more information about limitations and exceptions, see the plan or policy document at mbaccess.medben.com (select MedBen Access).

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)	
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
If you need drugs to treat your illness or condition through MedBenRX, contact MedBen's Customer Service Department at 1-800-686-8425.	Generic drugs (Tier 1)	\$10 <u>copayment</u> per 30-day supply and \$20 <u>copayment</u> per 90-day supply	Not covered except through retail/mail order	A <u>deductible</u> of \$1,700 per individual/\$3,400 per family must be met before the benefits apply. Amounts apply towards the medical <u>deductibles</u> listed on page one.
	Preferred brand drugs (Tier 2)	\$20 <u>copayment</u> per 30-day supply and \$40 <u>copayment</u> per 90-day supply	Not covered except through retail/mail order	
	Non-preferred brand drugs (Tier 3)	\$40 <u>copayment</u> per 30-day supply and \$80 <u>copayment</u> per 90-day supply	Not covered except through retail/mail order	Certain drugs are considered preventive and are covered at no charge. See Plan document for details.
	<u>Specialty drugs</u> (Tier 4)	\$160 <u>copayment</u> per 30-day supply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	Paid at in- <u>network</u> level	None.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	Emergency paid at in- <u>network</u> level; Non-emergency 40% <u>coinsurance</u>	Out-of-Network air ambulance paid at In-Network level.

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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)	
	<u>Urgent care</u>	20% <u>coinsurance</u>	Paid at in- <u>network</u> level	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-certification recommended.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-certification recommended for inpatient services.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<p><u>Cost sharing</u> does not apply for <u>preventive services</u>. Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).</p> <p>Pre-certification recommended after 48 hours following vaginal delivery or 96 hours following c-section.</p> <p>Dependent maternity is covered.</p> <p>No charge for breastfeeding support and supplies in-<u>network</u>.</p>
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Physical therapy and speech therapy limited to 10 visits each per calendar year maximum, additional visits may be allowed if medically necessary
	<u>Habilitation services</u>	Not Covered		
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-certification recommended.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Custom foot orthotics limited to 1 pair every three years. Diabetic shoes limited to one pair per calendar year or 3 shoe inserts per

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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)	
				calendar year maximum. One wig per lifetime following chemotherapy.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-certification recommended.
If your child needs dental or eye care	Children's eye exam	No Charge	40% <u>coinsurance</u>	If included in <u>preventive care</u> recommendations, visual acuity through age 21.
	Children's glasses	Not Covered	Not Covered	Separate vision coverage available
	Children's dental check-up	Not Covered	Not Covered	Separate dental coverage available

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.)		
<ul style="list-style-type: none"> Acupuncture; Bariatric surgery; Benefits paid as a result of injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances; Cosmetic surgery, unless otherwise listed in the Plan as covered; 	<ul style="list-style-type: none"> Dental care (Adult)- except for accidental dental coverage. Separate dental coverage is available; Infertility treatment; Long-term care; 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S.; Routine eye care (Adult)- separate coverage is available; Routine foot care- except when related to an underlying health condition; or Weight loss programs.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Dialysis services- outpatient services are subject to 125% of Medicare allowance. Out of-<u>network</u> paid at in-network level; 	<ul style="list-style-type: none"> Chiropractic care, limited to 10 visits per calendar year maximum; Hearing aids, through age 21: limited to one (1) per hearing impaired ear, up to \$2,500 every 48 months; aged 22 and over: limited to the initial purchase if the loss of hearing is a result of a surgical procedure; and 	<ul style="list-style-type: none"> Private-duty nursing, limited to 100 visits per calendar year maximum.

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 Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-866-267-2323 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. Other coverage options may be available to you, too, including buying

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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: MedBen's Customer Service Department at 1-800-686-8425 or mbaccess.medben.com (select MedBen Access). Additionally, a consumer assistance program may be available in your state to help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and at <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

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 1-800-862-6704.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-862-6704.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-862-6704.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-862-6704.

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 \$1,700.00
- Specialist copayment N/A
- 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,700.00
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,000.00
<i>What isn't covered</i>	
Limits or exclusions	\$60.00
The total Peg would pay is	\$2,760.00

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$1,700.00
- Specialist copayment N/A
- 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,700.00
<u>Copayments</u>	\$170.00
<u>Coinsurance</u>	\$210.00
<i>What isn't covered</i>	
Limits or exclusions	\$70.00
The total Joe would pay is	\$2,150.00

Mia's Simple Fracture

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

- The plan's overall deductible \$1,700.00
- Specialist copayment N/A
- 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,700.00
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$40.00
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,740.00

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