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 [contact name and number]. 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 www.heatlhcare.gov/sbc-glossary or call 1-800-409-1205 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: $250 Individual/$500 Family Out-of-Network: $500 Individual/$1,000 Family	Generally, you must pay all the costs 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 and primary 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?	For medical: In-Network: $1,500 Individual/ $3,000 Family Out-of-Network: $3,000 Individual/$6,000 Family For prescription drugs: $2,500 Individual/ $5,000 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?	Premiums, balance-billing charges, amounts greater than maximum benefits, penalties for failure to obtain preauthorization , Rx cost differentials, 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 aetnastateohioemployee.com or call 1-800-822-1152 for a list of Aetna network providers, stateofohio.medmutual.com or call 1-800-949-3104 for a list of Medical Mutual network providers, or enrollment.anthem.com/stateofohio or call 1-844-891-8359 for a list of Anthem 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
		In-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 copay/visit; deductible does not apply	$30 copay/visit, then 40% coinsurance	None
	Specialist visit	$25 copay/visit; deductible does not apply	$30 copay/visit, then 40% coinsurance	
	Other practitioner office visit	20% coinsurance for chiropractor;	40% coinsurance for chiropractor;	
	Preventive care/ screening/immunization	No charge	**Office visits** $30 copay/visit, then 40% coinsurance up to age 21; not covered if age 22-40; $30 copay/visit if age 40 or over **Other** 40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Routine physical and routine mammogram limited to once per plan year (in- and out-of-network combined). Frequency and age limitations may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.optumrx.com**.	Generic drugs	**Retail: 30-day supply** $10 copay/ prescription **Retail: 90-day supply** $30 copay/ prescription **Mail Order** $25 copay/90-day supply	Not covered	No charge for generic oral contraceptives. No charge for certain diabetic and tobacco cessation medications if plan requirements are met. Some generics are categorized as "single-source" and may result in a brand copay of $25. Drugs not listed in the formulary, investigational drugs, and drugs in clinical trials are not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider(You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Preferred brand-name drugs	**Retail: 30-day supply** $25 copay/ prescription **Retail: 90-day supply** $75 copay/ prescription **Mail Order** $62.50 copay/90-day supply	Not covered	No charge for preferred brand oral contraceptives when a generic is not available (retail and mail-order available). No charge for certain diabetic and tobacco cessation medications if plan requirements are met. Drugs not listed in the formulary, investigational drugs, and drugs in clinical trials are not covered. Certain drugs may require pre-authorization or approval. Visit **das.ohio.gov/prescriptiondrug** for more information.
	Non-preferred brand-name drugs	**Retail: 30-day supply** $50 copay/ prescription **Retail: 90-day supply** $150 copay/ prescription **Mail Order** $125 copay/90-day supply	Not covered	If brand-name medication is requested when generic equivalent is available, you will pay the difference in price in addition to your copay. No charge for non-preferred brand oral contraceptives when a generic is not available (retail and mail-order available). No charge for certain diabetic medications if plan requirements are met. Certain drugs may require preauthorization or approval. Visit **das.ohio.gov/prescriptiondrug** for more information. Drugs not listed in the formulary, investigational drugs, and drugs in clinical trials are not covered.
	Specialty drugs	See your costs above for preferred and non-preferred brand-name drugs	Not covered	Specialty medications must be obtained through Briova and are limited to a 30-day supply. The maximum copay for oral oncology medications is $100/30-day supply. For additional information, visit **das.ohio.gov/prescriptiondrug**.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider(You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay/visit; copay waived if admitted, then 20% coinsurance	$100 copay/visit; copay waived if admitted, then 20% coinsurance	None
	Emergency medical transportation	20% coinsurance; deductible does not apply	20% coinsurance; deductible does not apply	
	Urgent care	$30 copay, then 20% coinsurance; deductible does not apply	$35 copay, then 40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required for out-of-network care. $350 penalty may apply for failure to preauthorize.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	$20 copay/office visit; deductible does not apply	$30 copay/office visit, then 40% coinsurance	More information can be found at **www.liveandworkwell.com**.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	$350 penalty may apply for failure to preauthorize. More information can be found at **www.liveandworkwell.com**.
	Substance use disorder outpatient services	$20 copay/office visit; deductible does not apply	$30 copay/office visit, then 40% coinsurance	More information can be found at **www.liveandworkwell.com**.
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	$350 penalty may apply for failure to preauthorize. More information can be found at **www.liveandworkwell.com**.
If you are pregnant	Prenatal and postnatal care	No charge for initial visit (deductible does not apply), then 20% coinsurance	$30 copay/office visit, then 40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment, coinsurance, or deductible may apply.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider(You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Must be noncustodial. Limited to 100 visits/plan year or 180 days (whichever is greater), in- and out-of-network combined. Preauthorization required five business days before receiving services for out-of-network care. Financial penalty may apply or no benefit will be provided for failure to preauthorize.
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	20% coinsurance; office visit copay may apply	40% coinsurance: office visit copay may apply	Coverage includes diagnosis of Autism Spectrum Disorder.
	Skilled nursing care	20% coinsurance for first 180 days/plan year, then 40% coinsurance	20% coinsurance for first 180 days/plan year, then 40% coinsurance	Must be noncustodial. Must follow a hospital confinement or to avoid a hospitalization which would otherwise be necessary. Preauthorization for out-of-network care required and no benefit will be provided for failure to preauthorize.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice service	No charge	No charge	
If your child needs dental or eye care	Children's eye exam	No charge	$30 copay/office visit, then 40% coinsurance	Covered up to age 21 if in-network without deductible if eye exam is part of a preventive care/wellness examination.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	

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
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (unless medically necessary due to diabetes)
- Weight loss programs

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

- Bariatric surgery (medically necessary only)
- Chiropractic care
- Hearing aids (participant pays 20% coinsurance in-network and 40% out-of-network for covered accident, illness, or injury; for natural hearing loss, covered at 50% coinsurance up to $1,000 and limited to one per lifetime)
- Private duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-800-409-1205, option 5. You can also contact the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 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. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can visit aetnastateohioemployee.com or call 1-800-949-3104 (for Aetna); visit enrollment.anthem.com/stateofohio or call 1-844-891-8359 (for Anthem), or visit stateofohio.medmutual.com or call 1-800-822-1152 (for Medical Mutual).

Does this Coverage Provide Minimum Essential Coverage? **Yes**.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? **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.

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

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	$250
Specialist copayment	$25
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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$1,250
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,560**

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

The plan's overall deductible	$250
Specialist copayment	$25
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	**$7400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$250
Copayments	$845
Coinsurance	$27
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,177**

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

The plan's overall deductible	$250
Specialist copayment	$25
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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$250
Copayments	$75
Coinsurance	$326
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$651**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-409-1205, option 5. *Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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