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, visit hr.osu.edu/benefits/medical or call 614-292-1050 or 1-800-678-6010. 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 614-292-1050 or 1-800-678-6010 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$450 /individual or $900/family</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care and primary care visits are covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. $1,000 for infertility treatment and $50/individual or $100/family for prescription drugs.</td>
<td>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.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$2,600 individual / $5,200 family; For prescription drugs: $2,500 individual / $5,000 family</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Infertility services, weight management programs, non-essential specialty drugs, penalties for failure to obtain preauthorization for services, premiums, balance-billing charges and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes.</td>
<td>See <a href="https://hr.osu.edu/wp-content/uploads/osu-travel-assistance-card.pdf">https://hr.osu.edu/wp-content/uploads/osu-travel-assistance-card.pdf</a> or call 1-800-678-6269, option 6, for a list of network providers outside Ohio. See <a href="https://osuhealthplan.com/search">https://osuhealthplan.com/search</a> or call 1-800-678-6269 for a list of network providers in Ohio.</td>
</tr>
</tbody>
</table>
### Important Questions and Answers

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

* 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

<table>
<thead>
<tr>
<th>Event</th>
<th>Network Provider (You will pay the least)</th>
<th>Out of Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>No charge</td>
<td>No charge</td>
<td>None</td>
</tr>
</tbody>
</table>
| Specialist visit | 20% coinsurance | 20% coinsurance | Out-of-network services subject to balance-billing. 
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. |
| Preventive care/screening/immunization | No charge | No charge | |
| **If you have a test** | | | |
| Diagnostic test (x-ray, blood work) | 20% coinsurance | 20% coinsurance | Out-of-network services subject to balance-billing. |
| Imaging (CT/PET scans, MRIs) | 20% coinsurance | 20% coinsurance | |
| **If you need drugs to treat your illness or condition** | | | |
| Generic drugs | Preferred Pharmacy: $10 copay /prescription for retail; $25 copay /prescription for home delivery or Retail90; no charge for value-based program; deductible does not apply. Non-Preferred Pharmacy: $20 copay/prescription for retail; value-based program not covered; | Preferred Pharmacy: $10 copay /prescription for retail; $25 copay /prescription for home delivery or Retail90; no charge for value-based program; deductible does not apply. Non-Preferred Pharmacy: $20 copay/prescription for retail; value-based program not covered; | Covers up to a 30-day supply (retail), up to a 90-day supply (home delivery or Retail90). Out-of-network prescription drugs are not covered. |

* For more information about limitations and exceptions, see the plan or policy document at www.hr.osu.edu/benefits/medical
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Formulary brand drugs (Preferred brand drugs)</strong></td>
<td></td>
<td><strong>Network Provider (You will pay the least)</strong></td>
<td><strong>Out of Network Provider (You will pay the most)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>deductible does not apply.</td>
<td>deductible does not apply.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preferred Pharmacy: 30% coinsurance for retail, home delivery and Retail90; 15% coinsurance for value-based program. Non-Preferred Pharmacy: 35% coinsurance for retail; value-based program not covered.</td>
<td>Preferred Pharmacy: 30% coinsurance for retail, home delivery and Retail90; 15% coinsurance for value-based program. Non-Preferred Pharmacy: 35% coinsurance for retail; value-based program not covered.</td>
</tr>
<tr>
<td><strong>Non-formulary brand drugs (Non-preferred brand drugs)</strong></td>
<td></td>
<td>Preferred Pharmacy: 50% coinsurance for retail, home delivery and Retail90. Non-Preferred Pharmacy: 55% coinsurance</td>
<td>Preferred Pharmacy: 50% coinsurance for retail, home delivery and Retail90. Non-Preferred Pharmacy: 55% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialty drugs</strong></td>
<td></td>
<td>20% coinsurance for generic and formulary brand name; 50% coinsurance for non-formulary brand name; deductible does not apply to generics If enrolled in the</td>
<td>20% coinsurance for generic and formulary brand name; 50% coinsurance for non-formulary brand name; deductible does not apply to generics If enrolled in the</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see the plan or policy document at www.hr.osu.edu/benefits/medical*
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<tr>
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<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out of Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance</td>
<td>Outpatient services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at www.hr.osu.edu/benefits/medical

Copay for non-essential health benefit specialty drugs under the SaveonSP program do not accumulate to the prescription drug out-of-pocket limit.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out of Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>abuse services</td>
<td></td>
<td></td>
<td></td>
<td>services subject to balance-billing.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Out-of-network services subject to balance-billing.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Preauthorization is required, except emergency admissions must be authorized within one business day. If not obtained, claims may be denied or a penalty applied of 20% of the fee, up to $1,000 per admission or service. Out-of-network services subject to balance-billing.</td>
</tr>
<tr>
<td></td>
<td>professional services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>facility services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Preauthorization is required. If not obtained, claims may be denied or a penalty applied of 20% of the fee, up to $1,000 per admission or service. Out-of-network services subject to balance-billing.</td>
</tr>
<tr>
<td>recovering or have</td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Coverage for occupational and physical therapy outpatient services is limited to a combined maximum of 45 visits per year. Coverage for speech therapy is limited to 20 visits per year. Out-of-network services subject to balance-billing.</td>
</tr>
<tr>
<td>other special health needs</td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Coverage for extended care facility is limited to 60 days per year. Preauthorization is required, except for durable medical equipment, which requires preauthorization for services over $2,000. If not obtained, claims may be denied or a penalty applied of 20% of the fee, up to $1,000 per</td>
</tr>
<tr>
<td></td>
<td>Durable medical</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at www.hr.osu.edu/benefits/medical
### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out of Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td>admission, service, or claim. Out-of-network services subject to balance-billing.</td>
<td></td>
</tr>
<tr>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

### 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 (Adult & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)

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

- Acupuncture ($2,000 annual maximum, combined with chiropractic care)
- Bariatric Surgery
- Chiropractic care ($2,000 annual maximum, combined with acupuncture)
- Hearing aids (20% coinsurance after deductible up to $1,400/single, $2,800/bilateral every three years)
- Infertility treatment (50% coinsurance after separate deductible of $1,000/person, combined $15,000 medical and prescription drug lifetime maximum)
- Routine foot care
- Weight loss programs (50% coinsurance)

### 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: Trustmark at 1-866-442-8257, OSU Health Plan at 1-800-678-6269 or 614-292-4700, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or https://www.cms.gov/cciio/. 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: Trustmark at 1-866-442-8257 or OSU Health Plan at 1-800-678-6269 or 614-292-4700.

* For more information about limitations and exceptions, see the plan or policy document at www.hr.osu.edu/benefits/medical
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 1-800-264-1552, x80014189.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-264-1552, x80014189.
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-264-1552, x80014189.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-264-1552, x80014189

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

* For more information about limitations and exceptions, see the plan or policy document at www.hr.osu.edu/benefits/medical
**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 network pre-natal care and a hospital delivery)

- The plan’s overall deductible $450
- Specialist [cost sharing] 20%
- Hospital (facility) [cost sharing] 20%
- Other [cost sharing] 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

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$450</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,200</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $60

The total Peg would pay is $2,660

---

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

- The plan’s overall deductible $450
- Specialist [cost sharing] 20%
- Hospital (facility) [cost sharing] 20%
- Other [cost sharing] 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

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$100</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,100</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $20

The total Joe would pay is $1,720

---

**Mia’s Simple Fracture**
(Network emergency room visit and follow up care)

- The plan’s overall deductible $450
- Specialist [cost sharing] 20%
- Hospital (facility) [cost sharing] 20%
- Other [cost sharing] 20%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic tests (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

Total Example Cost $2,800

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$450</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$500</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $0

The total Mia would pay is $960

---

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: Office of Human Resources, 614-292-1050 or 1-800-678-6010. *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.