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.

### Important Questions Answers Why This Matters:

<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, 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>Not Applicable.</td>
<td>This plan does not use a provider network. You can receive covered services from any provider.</td>
</tr>
<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.

<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>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>No charge</td>
<td>None.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>Subject to <strong>balance billing</strong>.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>Subject to <strong>balance billing</strong>.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>
| 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; deductible does not apply | 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.
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| **Formulary brand name drugs** | 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 | Covers up to a 30-day supply (retail), up to a 90-day supply (home delivery or Retail90). Certain prescription drugs require preauthorization.  
Preferred Pharmacy: $100 maximum (formulary brand name, retail), $50 maximum (formulary brand name, value-based retail)  
Non-Preferred Pharmacy: $110 maximum (formulary brand name, retail)  
Home Delivery/Retail90: $250 maximum (formulary brand name, home delivery/Retail90), $125 maximum (formulary brand name, value-based home delivery)  
Out-of-Network prescription drugs are not covered. | |
| **Non-formulary brand name drugs** | Preferred Pharmacy: 50% coinsurance for retail, home delivery and Retail90.  
Non-Preferred Pharmacy: 55% coinsurance | Covers up to a 30-day supply (retail), up to a 90-day supply (home delivery or Retail90). Certain prescription drugs require preauthorization. Out-of-Network prescription drugs are not covered. | |
| **Specialty drugs** | 20% coinsurance for generic and formulary brand name;  
50% coinsurance for non-formulary brand name; deductible does not apply to generics | Covers up to a 30-day supply. Must use Ohio State University Outpatient Pharmacy or Accredro Pharmacy. $50 maximum (generic), $100 maximum (formulary brand name). Certain prescription drugs require preauthorization. Out-of-Network prescription drugs are not covered. | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center)  
Physician/surgeon fees | 20% coinsurance  
20% coinsurance | Subject to balance billing. |
| **If you need immediate medical attention** | Emergency room care  
Emergency medical transportation  
Urgent care | 20% coinsurance  
20% coinsurance  
20% coinsurance | None  
None  
Subject to balance billing. |
<p>| <strong>If you have a hospital stay</strong> | Facility fee (e.g., hospital room) | 20% coinsurance | Preauthorization is required, except emergency admissions must be authorized within one business day. If not obtained, |</p>
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<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>claims may be denied or a penalty applied of 20% of the fee, up to $1,000 per admission or service. Subject to balance billing.</td>
</tr>
<tr>
<td></td>
<td>Outpatient services</td>
<td>20% coinsurance</td>
<td>Preauthorization is required for inpatient care, 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. Subject to balance billing.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</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. Subject to balance billing.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>Subject to balance billing.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</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. Subject to balance billing. 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. Subject to balance billing.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td></td>
</tr>
</tbody>
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* For more information about limitations and exceptions, see the plan or policy document at [www.hr.osu.edu/benefits/medical](http://www.hr.osu.edu/benefits/medical).
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<tr>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td></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 admission, service, or claim. Subject to balance billing.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If your child needs dental or eye care:
- Children’s eye exam: Not covered
- Children’s glasses: Not covered
- Children’s dental check-up: 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.):**
- 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 $1,200 every four years)
- Infertility treatment (paid at 50% coinsurance after separate deductible of $1,000/person, combined $15,000 medical and prescription drug lifetime maximum)
- Routine foot care
- Weight loss programs (paid at 50% coinsurance, $1,000 combined annual 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: CoreSource 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 www.cms.gov/ccio. 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.

* For more information about limitations and exceptions, see the plan or policy document at www.hr.osu.edu/benefits/medical.
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, contact: CoreSource at 1-866-442-8257 or OSU Health Plan at 1-800-678-6269 or 614-292-4700.

Does this plan 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 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): Dinekehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-264-1552, x80014189.

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

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* 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 in-network pre-natal care and a hospital delivery)

- **The plan’s overall deductible**: $450
- **Specialist coinsurance**: 20%
- **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**: $12,800

**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>$2,150</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 in-network care of a well-controlled condition)

- **The plan’s overall deductible**: $450
- **Specialist coinsurance**: 20%
- **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**: $7,400

**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>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60

**The total Joe would pay is**: $2,360

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

- **The plan’s overall deductible**: $450
- **Specialist coinsurance**: 20%
- **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**: $1,900

**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>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$400</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0

**The total Mia would pay is**: $850

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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.