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><strong>What is the overall deductible?</strong></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><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Network 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><strong>Are there other deductibles for specific services?</strong></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><strong>What is the out-of-pocket limit for this plan?</strong></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><strong>What is not included in the out-of-pocket limit?</strong></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><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://www.osuhealthplan.com/search/">www.osuhealthplan.com/search/</a> or call 614-292-4700 or 1-800-678-6269 for a list of network</td>
<td>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.</td>
</tr>
<tr>
<td>Important Questions</td>
<td>Answers</td>
<td>Why This Matters:</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Do you need a referral to</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
<tr>
<td>see a specialist?</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](http://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></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 need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>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</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Formulary brand name drugs</td>
<td>Preferred Pharmacy: 30% coinsurance for retail, home delivery and Retail90; 15% coinsurance for value-based program</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-formulary brand name drugs</td>
<td>Preferred Pharmacy: 50% coinsurance for retail, home delivery and Retail90. Non-Preferred Pharmacy: 55% coinsurance</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* 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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<td><strong>Network Provider</strong></td>
<td><strong>Out-of-Network Provider</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Limitations, Exceptions, &amp; Other Important Information</strong></td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td></td>
<td>20% <strong>coinsurance</strong> for generic and formulary brand name; 50% <strong>coinsurance</strong> for non-formulary brand name; <strong>deductible</strong> does not apply to generics</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% <strong>coinsurance</strong></td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Physician/surgeon fees</td>
<td>20% <strong>coinsurance</strong></td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Emergency room care</td>
<td>20% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency medical transportation</td>
<td>20% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% <strong>coinsurance</strong></td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% <strong>coinsurance</strong></td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>If you need mental health, behavioral health, or substance abuse services</th>
<th>Outpatient services</th>
<th>20% coinsurance; deductible does not apply</th>
<th>Not covered</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance</td>
<td>Not covered</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.</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td></td>
<td></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>Not covered</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.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>Not covered</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.</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>Not covered</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.</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</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](http://www.hr.osu.edu/benefits/medical).
### 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.**)

<table>
<thead>
<tr>
<th>Excluded Services</th>
<th>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Cosmetic Surgery</td>
<td>- Acupuncture ($2,000 annual maximum, combined with chiropractic care)</td>
</tr>
<tr>
<td>- Dental care (Adult &amp; Child)</td>
<td>- Hearing aids (20% coinsurance after deductible up to $1,200 every four years)</td>
</tr>
<tr>
<td>- Long-term care</td>
<td>- Infertility treatment (paid at 50% coinsurance after separate deductible of $1,000/person, combined $15,000 medical and prescription drug lifetime maximum)</td>
</tr>
<tr>
<td>- Non-emergency care when traveling outside the U.S.</td>
<td>- Routine foot care</td>
</tr>
<tr>
<td>- Private-duty nursing</td>
<td>- Weight loss programs (paid at 50% coinsurance, $1,000 combined annual maximum)</td>
</tr>
<tr>
<td>- Routine eye care (Adult &amp; Child)</td>
<td></td>
</tr>
</tbody>
</table>

### 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.

### 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 lumawag 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): Dine’ehgo shika a’t’ohwol ninisingo, kwiijigo holne’ 1-800-264-1552, x80014189.

* 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
</tbody>
</table>

- **The plan’s overall deductible** | **$450** | **$450** | **$450** |
- **Specialist coinsurance** | **20%** | **20%** | **20%** |
- **Hospital (facility) coinsurance** | **20%** | **20%** | **20%** |
- **Other coinsurance** | **20%** | **20%** | **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** | **$7,400** | **$1,900**

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td><strong>$450</strong></td>
</tr>
<tr>
<td>Copayments</td>
<td><strong>$0</strong></td>
</tr>
<tr>
<td>Coinsurance</td>
<td><strong>$2,150</strong></td>
</tr>
</tbody>
</table>

**What isn’t covered** | **$60** |
| Limits or exclusions |  |

**The total Peg would pay is** | **$2,660** |

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td><strong>$500</strong></td>
</tr>
<tr>
<td>Copayments</td>
<td><strong>$300</strong></td>
</tr>
<tr>
<td>Coinsurance</td>
<td><strong>$1,500</strong></td>
</tr>
</tbody>
</table>

**What isn’t covered** | **$60** |
| Limits or exclusions |  |

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

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td><strong>$450</strong></td>
</tr>
<tr>
<td>Copayments</td>
<td><strong>$0</strong></td>
</tr>
<tr>
<td>Coinsurance</td>
<td><strong>$400</strong></td>
</tr>
</tbody>
</table>

**What isn’t covered** | **$0** |
| Limits or exclusions |  |

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

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.