The Ohio State University: Prime Care Advantage

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 – 12/31/2017

Coverage for: Employee Only, Employee + Children, Employee + Spouse, Family

| Plan Type: EPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at hr.osu.edu/benefits/medical or by calling 614-292-1050 or 1-800-678-6010.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$450** person **/ $900** family Does not apply to primary care provider office visits, prescription drugs, urgent care, infertility treatment, weight loss surgery, outpatient services for mental health and substance abuse, immunizations and preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	Yes. **$1,000** for infertility treatment, **$400** for weight loss surgery and **$50** person / **$100** family for prescription drugs. There are no other specific **deductibles**.	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.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,500** person **/ $5,000** family **$2,500** person **/ $5,000** family for prescription drugs.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Infertility services, weight management programs, prior authorization penalties, premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of network providers see: Osuhealthplan.com/search or call 1-800-678-6269.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 9. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	——————————none——————————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Specialist visit	20% coinsurance	Not covered	——————none——————
	Other practitioner office visit	20% coinsurance	Not covered	Acupuncture and chiropractic treatments have a combined maximum benefit of $2,000 per plan year.
	Preventive care/screening/immunization	No charge	Not covered	Age and frequency schedules apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at hr.osu.edu/benefits/prescription	Generic drugs	Preferred Pharmacy: $10/ prescription for retail; $25/ prescription for home delivery; $0/ prescription for value-based program. Non-Preferred Pharmacy: $20/ prescription for retail; value-based program not covered.	Not covered	Must use a network pharmacy. Covers up to a 30-day supply (retail), up to a 90-day supply (home delivery). No deductible for generics.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Formulary brand name drugs	Preferred Pharmacy: 30% coinsurance for retail and home delivery; 15% coinsurance for value-based program. Non-Preferred Pharmacy: 35% coinsurance for retail; value-based program not covered	Not covered	Must use a network pharmacy. Covers up to a 30-day supply (retail), up to a 90-day supply (home delivery). $50 person / $100 family deductible for all prescriptions except generics. Certain prescription drugs are not covered without prior authorization. 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: $250 maximum (formulary brand name, home delivery), $125 maximum (formulary brand name, value-based home delivery)

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Non-formulary brand name drugs	50% coinsurance for Preferred Pharmacy and home delivery; 55% coinsurance for Non-Preferred Pharmacy	Not covered	Must use a network pharmacy. Covers up to a 30-day supply (retail), up to a 90-day supply (home delivery). $50 person / $100 family deductible for all prescriptions except generics. Certain prescription drugs are not covered without prior authorization.
	Specialty drugs	20% coinsurance (generic and formulary brand name); 50% coinsurance (non-formulary brand name)	Not covered	Must use Ohio State University Specialty Pharmacy or Accredo Pharmacy. Covers up to a 30-day supply. $50 person / $100 family deductible for all prescriptions except generics. $9 minimum and $38 maximum (generic), $84 maximum (formulary brand name). Certain prescription drugs are not covered without prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	——————none——————
	Physician/surgeon fees	20% coinsurance	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	——————none——————
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	20% coinsurance	20% coinsurance	No deductible for urgent care visits. No network restrictions outside Ohio.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Prior authorization 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.
	Physician/surgeon fee	20% coinsurance	Not covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	Not covered	No deductible for outpatient care. Prior authorization is required for inpatient and facility-based 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.
	Mental/Behavioral health inpatient services	20% coinsurance	Not covered	
	Substance use disorder outpatient services	20% coinsurance	Not covered	
	Substance use disorder inpatient services	20% coinsurance	Not covered	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	Not covered	——————none——————
	Delivery and all inpatient services	20% coinsurance	Not covered	Prior authorization 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.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Prior authorization 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.
	Rehabilitation services	20% coinsurance	Not covered	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.
	Habilitation services	20% coinsurance	Not covered	
	Skilled nursing care	20% coinsurance	Not covered	Coverage for extended care facility is limited to 60 days during period of 36 consecutive months. Prior authorization is required, except for durable medical equipment, which requires prior authorization 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 or service.
	Durable medical equipment	20% coinsurance	Not covered	
	Hospice service	20% coinsurance	Not covered	
If your child needs dental or eye care	Eye exam	Not covered	Not covered	——————none——————
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Long-term care
- Non-emergency care when traveling outside the United States
- Private-duty nursing
- Routine eye care (Adult & Child)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (combined $2,000 annual maximum)
- Bariatric surgery (paid at 70% after $400 deductible, $25,000 lifetime maximum on weight management programs)
- Chiropractic care (combined $2,000 annual maximum)
- Hearing aids (paid at 80% after deductible up to $1,200 every four years)
- Infertility treatment (paid at 50% after $1,000 annual deductible, combined $15,000 medical and prescription drug lifetime maximum)
- Routine foot care
- Weight loss programs (paid at 50%, $1,000 combined annual maximum, $25,000 lifetime maximum on weight management programs)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-44-BUCKS (442-8257). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: CoreSource at 1-866-442-8257 or OSU Health Plan at 1-800-678-6269 or 614-292-4700.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 614-293-3369.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-264-1552, x987.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 614-293-3369.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-264-1552, x987.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,560
- **Patient pays** $1,980

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$470
Copays	$0
Coinsurance	$1,360
Limits or exclusions	$150
Total	**$1,980**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,480
- **Patient pays** $920

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$450
Copays	$0
Coinsurance	$390
Limits or exclusions	$80
Total	**$920**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information, please contact the OSU Health Plan at 1-800-678-6269.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.