




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](http://hr.osu.edu/benefits/medical) or call 614- 247-6947 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 614-247-6947 or 1-800-678-6010 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$550/individual or \$1100/family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Network preventive care</a> and outpatient behavioral health visits are covered before you meet your <a href="#">deductible</a> . Premier <a href="#">network</a> primary care and specialist office visits are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$50/individual or \$100/family for <a href="#">prescription drugs</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$3,000 individual / \$6,000 family For <a href="#">prescription drugs</a> : \$2,500 individual / \$5,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Weight management programs, non-essential specialty drugs, penalties for failure to obtain <a href="#">preauthorization</a> for services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	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 <a href="#">network providers</a> .	You pay the least if you use a <a href="#">provider</a> in the Premier <a href="#">network</a> . You pay more if you use a <a href="#">provider</a> in the Standard <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		Premier Network Provider (You will pay the least)	Standard Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	No charge	30% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a> Deductible does not apply	30% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Not covered	
If you need drugs to treat your illness or	Generic drugs	Preferred Pharmacy: \$10 <a href="#">copay</a> /prescription for retail; \$25 <a href="#">copay</a> /prescription for home delivery or		Not covered	Covers up to a 30-day supply (retail), up to a 90-day supply (home delivery or Retail90).

\* 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)

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Premier Network Provider (You will pay the least)	Standard Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
<b>condition</b>  More information about <a href="http://hr.osu.edu/benefits/prescription-drug-coverage">prescription drug coverage</a> is available at <a href="http://hr.osu.edu/benefits/prescription/">hr.osu.edu/benefits/prescription/</a>		Retail90; no charge for value-based program; <a href="#">deductible</a> does not apply. Non-Preferred Pharmacy: \$20 <a href="#">copay</a> /prescription for retail; value-based program not covered; <a href="#">deductible</a> does not apply.			
	Formulary brand drugs (Preferred brand drugs)	Preferred Pharmacy: 30% <a href="#">coinsurance</a> for retail, home delivery and Retail90; 15% <a href="#">coinsurance</a> for value-based program. Non-Preferred Pharmacy: 35% <a href="#">coinsurance</a> for retail; value-based program not covered.	Not covered		Covers up to a 30-day supply (retail), up to a 90-day supply (home delivery or Retail90). Certain <a href="#">prescription drugs</a> require <a href="#">preauthorization</a> . 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)
	Non-formulary brand drugs (Non-preferred brand drugs)	Preferred Pharmacy: 50% <a href="#">coinsurance</a> for retail, home delivery and Retail90. Non-Preferred Pharmacy: 55% <a href="#">coinsurance</a>	Not covered		Covers up to a 30-day supply (retail), up to a 90-day supply (home delivery or Retail90). Certain <a href="#">prescription drugs</a> require <a href="#">preauthorization</a> .
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a> for generic and formulary brand name; 50% <a href="#">coinsurance</a> for non-formulary brand name; <a href="#">deductible</a> does not apply to generics. If enrolled in the SaveonSP program, certain <a href="#">specialty drugs</a> available at no charge. To enroll, contact SaveonSP at 1-800-683-1074.	Not covered		Covers up to 30-day supply. Must use Ohio State University Outpatient Pharmacy, Nationwide Children's Hospital Outpatient Pharmacy, or Accredo Pharmacy. \$50 maximum (generic), \$100 maximum (formulary brand name). Certain <a href="#">prescription drugs</a> require <a href="#">preauthorization</a> . Copay for non-essential health benefit <a href="#">specialty drugs</a> under the SaveonSP program do not accumulate to the prescription drug out-of-pocket limit.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Premier Network Provider (You will pay the least)	Standard Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Not covered	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Not covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Out-of-network services subject to <a href="#">balance billing</a> except ground (in Ohio) and air ambulance
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	No <a href="#">network</a> restrictions outside Ohio. <a href="#">Out-of-network provider</a> not covered inside Ohio.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required, except emergency admissions must be authorized within one business day. If not obtained, <a href="#">claims</a> may be denied or a penalty applied of 20% of the fee, up to \$1,000 per admission or service.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	Not covered	<a href="#">Preauthorization</a> is required for inpatient care, except emergency admissions must be authorized within one business day. If not obtained, <a href="#">claims</a> may be denied or a penalty applied of 20% of the fee, up to \$1,000 per admission or service.
	Inpatient services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Not covered	
If you are pregnant	Office visits	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required, except emergency admissions must be authorized within one business day. If not obtained, <a href="#">claims</a> may be denied or a penalty applied of 20% of the fee, up to \$1,000 per admission or service.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Not covered	

\* 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)

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Premier Network Provider (You will pay the least)	Standard Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required. If not obtained, <a href="#">claims</a> may be denied or a penalty applied of 20% of the fee, up to \$1,000 per admission or service
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	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.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Not covered	Coverage for extended care facility is limited to 60 days per year. <a href="#">Preauthorization</a> is required. If not obtained, <a href="#">claims</a> may be denied or a penalty applied of 20% of the fee, up to \$1,000 per admission, service, or <a href="#">claim</a> .
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Not covered	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental care (Adult &amp; Child)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult &amp; Child)</li> </ul>

\* 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)

**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 3 years)
- Infertility treatment (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 [www.cciio.cms.gov](http://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](http://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.

**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, kwijigo 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.*

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 PREMIER network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$550
- [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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:  
*Cost Sharing*

<a href="#">Deductibles</a>	\$550
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,400

*What isn't covered*

Limits or exclusions	\$60
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<b>The total Peg would pay is</b>	<b>\$3,020</b>
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**Managing Joe's Type 2 Diabetes**

(a year of routine PREMIER network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$550
- [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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:  
*Cost Sharing*

<a href="#">Deductibles</a>	\$600
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$1,100

*What isn't covered*

Limits or exclusions	\$20
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<b>The total Joe would pay is</b>	<b>\$1,820</b>
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**Mia's Simple Fracture**

(PREMIER network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$550
- [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 test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:  
*Cost Sharing*

<a href="#">Deductibles</a>	\$550
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$400

*What isn't covered*

Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$960</b>
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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, 614-247-6947 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.