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- 247-6947or 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 614-247-6947or 1-800-678-6010 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$150/individual or $300/family	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.
Are there services covered before you meet your deductible?	Yes. Network preventive care and primary care visits are covered before you meet your deductible.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	$1,500 individual / $3,000 family; For prescription drugs: $2,000 individual/ $4,000 family	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.
What is not included in the out-of-pocket limit?	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.	Even though you pay these expenses, they don't count toward the out-of-pocket limit
Will you pay less if you use a network provider?	Yes. See https://osuhealthplan.com/search or call 614-292-4700 or 1-800-678-6269 for a list of network providers.	You pay the least if you use a provider in the Premier network. You pay more if you use a provider in the Standard 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 (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 the more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	$20 copay/visit; deductible does not apply	Not covered	None
	Specialist visit	$20 copay/visit; deductible does not apply	$30 copay/visit; deductible does not apply	Not covered	
	Preventive care/screening/ immunization	No charge	No charge	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance; deductible does not apply	25% coinsurance; deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance; deductible does not apply	25% coinsurance; deductible does not apply	Not covered	
If you need drugs to treat your illness or condition	Generic drugs	Preferred Pharmacy: $8 copay/prescription for retail; $20 copay/prescription for home delivery or Retail90; no charge for value-based program; deductible does not apply. Non-Preferred Pharmacy: $18 copay/prescription for retail; value-based program not covered; deductible does not apply.		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

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 the more)	Out-of-Network Provider (You will pay the most)	
More information about prescription drug coverage is available at hr.osu.edu/benefits/prescription/	Formulary brand drugs (Preferred brand 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.		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: $40 maximum (formulary brand name, retail), $20 maximum (formulary brand name, value-based retail). Non-Preferred Pharmacy: $50 maximum (formulary brand name, retail). Home Delivery/Retail90: $100 maximum (formulary brand name, home delivery/Retail90), $50 maximum (formulary brand name, value-based home delivery/Retail90).
	Non-formulary brand drugs (Non-preferred brand drugs)	Preferred Pharmacy: 50% coinsurance for retail, home delivery and Retail90. Non-Preferred Pharmacy: 55% coinsurance		Not covered	Covers up to a 30-day supply (retail), up to a 90-day supply (home delivery or Retail90). Certain prescription drugs are not covered without preauthorization
	Specialty drugs	20% coinsurance for generic and formulary brand name; 50% coinsurance for non-formulary brand name. If enrolled in the SaveonSP program, certain specialty drugs available at no charge. To enroll, contact SaveonSP at 1-800-683-1074.		Not covered	Covers up to a 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

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 the more)	Out-of-Network Provider (You will pay the most)	
					name). Certain prescription drugs require preauthorization Copay for non-essential health benefit specialty drugs under the SaveonSP program do not accumulate to the prescription drugs out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay/visit; deductible does not apply	$150 copay/visit; deductible does not apply	Not covered	None
	Physician/surgeon fees	No charge	No charge	Not covered	
If you need immediate medical attention	Emergency room care	$100 copay/visit; deductible does not apply	$100 copay/visit; deductible does not apply	$100 copay/visit; deductible does not apply	None
	Emergency medical transportation	No charge	No charge	No charge	Out-of-network services subject to balance billing except ground (in Ohio) and air ambulance
	Urgent care	$35 copay/visit; deductible does not apply	$35 copay/visit; deductible does not apply	$35 copay/visit; deductible does not apply	No network restrictions outside Ohio. Out-of-network providers, not covered inside Ohio.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/admission; deductible does not apply	$300 copay/admission; deductible does not apply	Not covered	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
	Physician/surgeon fees	No charge	No charge	Not covered	None
If you need mental	Outpatient services	No charge	No charge	Not covered	Preauthorization is required for

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 the more)	Out-of-Network Provider (You will pay the most)	
health, behavioral health, or substance abuse services	Inpatient services	$200 copay/admission; deductible does not apply	$300 copay/admission; deductible does not apply	Not covered	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.
If you are pregnant	Office visits	$20 copay	$30 copay	Not covered	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.
	Childbirth/delivery professional services	No charge	No charge	Not covered	
	Childbirth/delivery facility services	$200 copay/admission; deductible does not apply	$300 copay/admission; deductible does not apply	Not covered	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	25% coinsurance	Not covered	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.
	Rehabilitation services	$20 copay/visit; deductible does not apply	$30 copay/visit; deductible does not apply	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 copay/visit; deductible does not apply	$30 copay/visit; deductible does not apply	Not covered	
	Skilled nursing care	$50 copay/admission; deductible does not apply	$75 copay/admission; deductible does not apply	Not covered	Coverage for extended care facility is limited to 60 days per year. Preauthorization is required, except for durable medical equipment, which
	Durable medical equipment	15% coinsurance	25% coinsurance	Not covered	

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 the more)	Out-of-Network Provider (You will pay the most)	
	Hospice services	No charge	No charge	Not covered	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.
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 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 (15% coinsurance after deductible up to $1,400/single, $2,800/bilateral every three 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 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.

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.

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	**$150**
Specialist *[cost sharing]*	**$20**
Hospital (facility) *[cost sharing]*	**$200**
Other *[cost sharing]*	**$0**

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:	
Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$660**

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

The plan's overall deductible	**$150**
Specialist *[cost sharing]*	**$20**
Hospital (facility) *[cost sharing]*	**$200**
Other *[cost sharing]*	**$0**

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:	
Cost Sharing	
Deductibles	$150
Copayments	$200
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,370**

Mia's Simple Fracture
(**PREMIER** network emergency room visit and follow up care)

The plan's overall deductible	**$150**
Specialist *[cost sharing]*	**$20**
Hospital (facility) *[cost sharing]*	**$200**
Other *[cost sharing]*	**$0**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$150
Copayments	$400
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$580**

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, 614-247-6947or 1-800-678-6010.

The plan would be responsible for the other costs of these EXAMPLE covered services.