




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, go to: das.ohio.gov/benefits. 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 <http://www.healthcare.gov/sbc-glossary> or call 1-800-409-1205 (option 2) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- network : \$400/Individual or \$800/Family. Out-of-network : \$800/Individual or \$1,600/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. Preventive care and primary care services 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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: In- network : \$2,500/Individual or \$5,000/Family. Out-of-network : \$5,000/Individual or \$10,000/Family. Prescription drugs: \$3,500/Individual or \$7,000/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?	Premiums , balance billing charges, amounts greater than maximum benefits, penalties for failure to obtain preauthorization , Rx cost differentials, 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 stateofohio.medmutual.com or call 1-800-949-3104 for a list of Medical Mutual network providers, or enrollmentanthem.com/stateofohio or call 1-844-891-8359 for a list of Anthem network providers .	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 (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
		Network Provider (You will pay the least)	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	\$30 copay /visit; deductible does not apply	\$50 copay /office visit, then 40% coinsurance	None
	Specialist visit	\$35 copay /visit; deductible does not apply	\$55 copay /visit, then 40% coinsurance	None
	Preventive care/screening/immunization	No charge	Office visits: \$50 copay /visit, then 40% coinsurance up to age 21; not covered if age 22-40; \$50 copay /visit if age 40 or over. Other Services and procedures: 40% coinsurance	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. Routine physical and routine mammogram limited to once per plan year (in- and out-of-network combined). Frequency and age limitations may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com	Generic drugs	Retail: \$10 copay /prescription (30-day supply); \$30 copay /prescription (90-day supply); Mail Order \$25 copay (90-day supply)	Not covered	Maximum days' supply is 90. No charge for generic oral contraceptives. No charge for certain diabetic and tobacco cessation medications if plan requirements are met. Some generics are categorized as "single-source" and may result in a brand copay of \$40. Drugs not listed in the formulary , investigational drugs, and drugs in clinical trials are not covered. If a brand-name medication is requested when a generic
	Preferred brand-name drugs	Retail: \$40 copay /prescription (30-day	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		supply); \$120 copay /prescription (90-day supply) Mail Order \$100 copay (90-day supply)		equivalent is available, you will pay the difference in price in addition to your copay . No charge for preferred or non-preferred brand oral contraceptives when a generic is not available (retail and mail-order available). No charge for certain diabetic medications and tobacco cessation medications if plan requirements are met. Certain drugs may require preauthorization or approval. Visit das.ohio.gov/prescriptiondrug for more information. Drugs not listed in the formulary , investigational drugs, and drugs in clinical trials are not covered.
	Non-preferred brand-name drugs	Retail: \$75 copay /prescription (30-day supply); \$225 copay /prescription (90-day supply) Mail Order \$187.50 copay (90-day supply)	Not covered	
	Specialty drugs	See your costs above for preferred and non-preferred brand-name drugs	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	\$150 copay /visit, then 20% coinsurance	\$150 copay /visit, then 20% coinsurance	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance ; deductible does not apply	20% coinsurance ; deductible does not apply	
	Urgent care	\$40 copay , then 20% coinsurance ; deductible does not apply	\$60 copay , then 40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required for out-of-network care. \$350 penalty may apply for failure to preauthorize.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health or substance use disorder outpatient services	\$30 copay /office visit; deductible does not apply	\$50 copay /office visit, then 40% coinsurance	\$350 penalty may apply for failure to preauthorize for inpatient services. More information can be found at das.ohio.gov/behavioralhealth
	Mental/Behavioral health or substance use disorder inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	Covered in full	40% coinsurance	Cost sharing does not apply for all in-network maternity care. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	Covered in full	40% coinsurance	
	Childbirth/delivery facility services	Covered in full	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Must be noncustodial. Limited to 100 visits/ plan year or 180 days (whichever is greater), in- and out-of-network combined. Preauthorization required five business days before receiving services for out-of-network care. No benefit will be provided for failure to preauthorize.
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	20% coinsurance ; office visit copay may apply	40% coinsurance ; office visit copay may apply	Coverage includes diagnosis of Autism Spectrum Disorder.
	Skilled nursing care	20% coinsurance for first 180 days/ plan year, then 40% coinsurance	20% coinsurance for first 180 days/ plan year, then 40% coinsurance	Must be noncustodial. Must follow a hospital confinement or to avoid a hospitalization which would otherwise be necessary. Preauthorization for out-of-network care required and no benefit will be provided for failure to preauthorize.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	No charge	No charge	None
If your child needs dental or eye care	Children's eye exam	No charge	\$50 copay /office visit, then 40% coinsurance	Covered up to age 21 if in-network without deductible if eye exam is part of a preventive care /wellness examination.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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 .)			
<ul style="list-style-type: none"> Acupuncture Cosmetic surgery Dental care (Adult) 	<ul style="list-style-type: none"> Long-term care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Routine eye care (Adult) Routine foot care (unless medically necessary due to diabetes) Weight loss programs 	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
<ul style="list-style-type: none"> Bariatric surgery (medically necessary only) Chiropractic care Infertility treatment 	<ul style="list-style-type: none"> Hearing aids (participant pays 20% coinsurance in-network and 40% out-of-network with a limit of one new/replacement every three years, excluding over the counter devices.) Private duty nursing

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 the [plan](#) is 1-800-409-1205, option 5 and contact information for the agencies is 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. 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, you can visit enrollmentanthem.com/stateofohio or call 1-844-891-8359 (for Anthem), or visit stateofohio.medmutual.com or call 1-800-822-1152 (for Medical Mutual).

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 1-800-382-5729 for Medical Mutual, 1-844-891-8359 for Anthem, 1-866-854-8850 for OptumRx, and 1-866-556-8166 for Optum Behavioral Solutions.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-382-5729 for Medical Mutual, 1-844-891-8359 for Anthem, 1-866-854-8850 for OptumRx, and 1-866-556-8166 for Optum Behavioral Solutions.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-382-5729 for Medical Mutual, 1-844-891-8359 for Anthem, 1-866-854-8850 for OptumRx, and 1-866-556-8166 for Optum Behavioral Solutions.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-382-5729 for Medical Mutual, 1-844-891-8359 for Anthem, 1-866-854-8850 for OptumRx, and 1-866-556-8166 for Optum Behavioral Solutions.

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

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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](#) \$400
- [Specialist copayment](#) \$35
- 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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$0

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$400
- [Specialist copayment](#) \$35
- 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles *	\$400
Copayments	\$800
Coinsurance	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,290

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$400
- [Specialist copayment](#) \$35
- 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	\$1,925
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles *	\$400
Copayments	\$200
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$900

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: 1-800-409-1205.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.