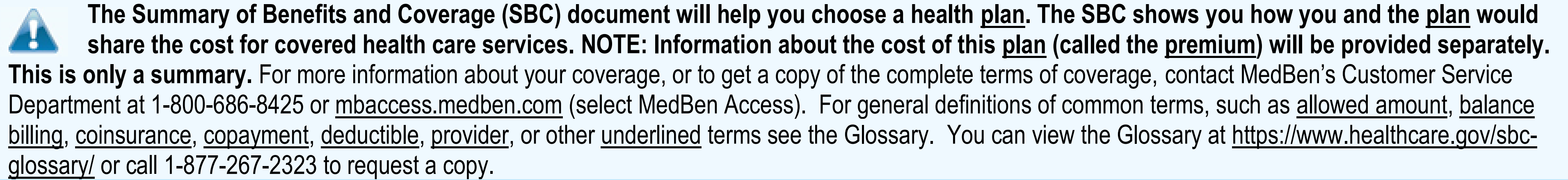
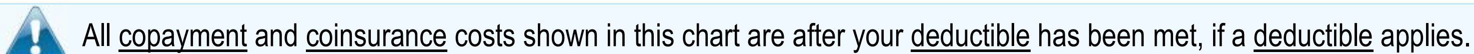


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact MedBen's Customer Service Department at 1-800-686-8425 or mbaccess.medben.com (select MedBen Access). 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 1-877-267-2323 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,000 for self-only coverage and $4,000 for family coverage per calendar year.	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive 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?	$2,000 for self-only coverage and $4,000 for family coverage per calendar year. For prescriptions filled through Walgreen's Pharmacy only, there is a separate out-of-pocket of $5,000 per individual and $10,000 per family which applies once the deductible is met.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balanced-billed charges and charges 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?	Not applicable.	This plan does not use a provider network, except in connection with organ/tissue transplants. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible only	Includes telehealth services during a State of Emergency.
	Specialist visit		
	Preventive care/screening/ immunization	No charge	Cologuard testing – once every 3 years. Routine hearing and visual acuity screening – through age 21. Mammography, pap smear and prostate exam – 1 per calendar year. Tobacco cessation counseling – 2 attempts to quit per year, with up to 4 sessions per attempt. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible only	Pre-certification recommended for MRI and PET scans.
	Imaging (CT/PET scans, MRIs)		
If you need drugs to treat your illness or condition For more information about prescription drug coverage that is available through Ventegra, contact MedBen's Customer Service Department at 1-800-686-8425.	Generic drugs	Deductible applies for 30 day supply retail or 90 day supply under mail order	Covered through retail/mail order programs only. Combination drugs are excluded. Once the Deductible has been met, the Covered Person will continue to be responsible for prescription charges filled through Walgreen's Pharmacy. Such charges apply to a separate out-of-pocket of $5,000 per individual and $10,000 per family.
	Preferred brand drugs	Deductible applies for 30 day supply retail or 90 day supply under mail order	
	Non-preferred brand drugs	Deductible applies for 30 day supply retail or 90 day supply under mail order	
	Specialty drugs	Not Covered *(for help with specialty medications, contact Rx Help Centers at 1-866-478-9593 or online at help@rxhelpcenters.com)*	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible only	No charge for all covered female elective sterilizations. Pre-certification recommended.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	Deductible only	None.
If you need immediate medical attention	Emergency room care	Deductible only	None.
	Emergency medical transportation	Deductible only	Includes air ambulance.
	Urgent care	Deductible only	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible only	Pre-certification recommended.
	Physician/surgeon fees	Deductible only	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Paid like other conditions	Pre-certification recommended for inpatient stays, residential treatment facilities and partial hospitalizations.
	Inpatient services	Deductible only	
If you are pregnant	Office visits	Deductible only	Dependent maternity is covered.
	Childbirth/delivery professional services	Paid like other conditions	
	Childbirth/delivery facility services	Deductible only	Pre-certification recommended after 48 hours following vaginal delivery or 96 hours following c-section.
If you need help recovering or have	Home health care	Deductible only	Limited to 100 visits per calendar year. Pre-certification recommended.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
other special health needs	Rehabilitation services	Deductible only	Physical and occupational therapy limited to 40 visits combined per calendar year. Speech therapy limited to 20 visits per calendar year. Cardiac rehabilitation only covered for phase I and II.
	Habilitation services	Deductible only	
	Skilled nursing care	Deductible only	Limited to 100 days per calendar year. Pre-certification recommended.
	Durable medical equipment	Deductible only	Wigs limited to 1 per calendar year maximum following cancer treatment or alopecia areata. Prosthetic bras following mastectomy limited to 4 per calendar year. Custom shoes and shoe orthotics limited to 1 per calendar year. Pre-certification recommended for prosthetics over $1,000, DME over $1,500 purchase or $500 monthly rental, except for braces or orthotics.
	Hospice services	Deductible only	Includes bereavement counseling within 6 months of death. Pre-certification recommended for inpatient.
If your child needs dental or eye care	Children's eye exam	No charge	Must be included in pediatric preventive care recommendations.
	Children's glasses	Deductible only	Covered only for 1st pair following cataract surgery. $200 limit in separate vision HRA coverage available.
	Children's dental check-up	Not Covered	Separate dental coverage available.

***Covered expenses for providers will be based on a percentage of the Medicare allowable rate for such service or pursuant to a direct health care provider contract, including, but not limited to dialysis services.**

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.)		
• Bariatric Surgery, • Benefits paid as a result of injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances, • Cosmetic Surgery,	• Dental Care (Adult), except for services related to an accident, covered up to 12 months after the accident, • Hearing Aids, • Infertility Treatment, except for corrections of defects preventing pregnancy, • Long Term Care,	• Private Duty Nursing, • Routine eye care (Adult), separate vision HRA coverage available, $200 for exams and $200 for materials, • Routine Foot Care, except when related to a metabolic or peripheral vascular disease, and • Weight Loss Programs.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic Care, spinal manipulation limited to 12 visits per calendar year, and	• Non-emergency care when traveling outside the U.S., unless travel was specifically to obtain such services.	

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-866-267-2323 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, contact: MedBen's Customer Service Department at 1-800-686-8425 or mbaccess.medben.com (select MedBen Access). Additionally, a consumer assistance program may be available in your state to help you file your appeal. Ohio does not currently have such a program. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and at http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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:

Para obtener asistencia en Español, llame al 1-800-862-6704.

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** **$2,000**
- **Specialist *copayment*** **NA**
- **Hospital (facility) *coinsurance*** **100%**
- **Other *coinsurance*** **100%**

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	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$600
The total Peg would pay is	**$2,600**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$2,000**
- **Specialist *copayment*** **NA**
- **Hospital (facility) *coinsurance*** **100%**
- **Other *coinsurance*** **100%**

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	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,000**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$2,000**
- **Specialist *copayment*** **NA**
- **Hospital (facility) *coinsurance*** **100%**
- **Other *coinsurance*** **100%**

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	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

Note: These numbers assume the patient does participate in the plan's wellness program. For more information about the wellness program, please contact: MedBen's Customer Service Department at 1-800-686-8425 or mbaccess.medben.com (select MedBen Access)

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