EPC - Southwestern Ohio Educational Purchasing Council: MABT - MV HDHP

**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, https://eoc.anthem.com/eocdps/aso. 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 www.healthcare.gov/sbc-glossary/ or call (855) 255-9952 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $4,000/person or $8,000/family for In-Network Providers. $8,000/person or $12,000/family for Non-Network Providers. | 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 policy, 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 (embedded). |
| **Are there services covered before you meet your deductible?** | Yes. Preventive Care for In-Network Providers. | 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?** | $6,350/person or $12,700/family for In-Network Providers. $13,000/person or $22,000/family for Non-Network Providers. | 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, the overall family out-of-pocket limit must be met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, health care this plan doesn't cover, and Non-Network Transplants. | 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, Blue Card PPO. See www.anthem.com or call (855) 255-9952 for a list of 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. |
| **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 |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Non-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% coinsurance | 50% coinsurance | --------none-------- |
| | Specialist visit | 30% coinsurance | 50% coinsurance | --------none-------- |
| | Preventive care/screening/ immunization | No charge | 50% 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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% coinsurance | 50% coinsurance | Costs may vary by site of service. |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | 50% coinsurance | Costs may vary by site of service. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.caremark.com. | Tier 1 - Typically Generic | 30% coinsurance for Retail & Home Delivery | Not covered | Provider means pharmacy for purposes of this section. Retail: Up to a 30-day supply Mail-Order: Up to a 90-day supply You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Notification requirement or may result in a higher cost. If you use a non-network Pharmacy, you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for |
| | Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs | 30% coinsurance for Retail & Home Delivery | Not covered | |
| | Tier 3 - Typically Non-Preferred Brand and Generic drugs | 30% coinsurance for Retail & Home Delivery | Not covered | |

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/aso.

| Common Medical Event | Services You May Need | What You Will Pay<br>In-Network Provider (You will pay the least) | What You Will Pay<br>Non-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | Tier 4 - Typically Preferred Specialty (brand and generic) | 30% coinsurance for Home Delivery | Not covered | certain prescribed drugs. Tier 1 Contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | 50% coinsurance | --------none-------- |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance | --------none-------- |
| **If you need immediate medical attention** | Emergency room care | 30% coinsurance | Covered as In-Network | --------none-------- |
| | Emergency medical transportation | 30% coinsurance | 50% coinsurance | Non-emergency non-network Ambulance Services are limited to $50,000 per trip. |
| | Urgent care | 30% coinsurance | 50% coinsurance | --------none-------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance | 50% coinsurance | --------none-------- |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance | --------none-------- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit<br>30% coinsurance<br>Other Outpatient<br>30% coinsurance | Office Visit<br>50% coinsurance<br>Other Outpatient<br>50% coinsurance | Office Visit<br>--------none--------<br>Other Outpatient<br>--------none-------- |
| | Inpatient services | 30% coinsurance | 50% coinsurance | --------none-------- |
| **If you are pregnant** | Office visits | 30% coinsurance | 50% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 30% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 30% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance | 50% coinsurance | --------none-------- |
| | Rehabilitation services | 30% coinsurance | 50% coinsurance | Costs may vary by site of service. *See Therapy Services section. |
| | Habilitation services | 30% coinsurance | 50% coinsurance | |
| | Skilled nursing care | 30% coinsurance | 50% coinsurance | --------none-------- |
| | Durable medical equipment | 30% coinsurance | 50% coinsurance | *See Durable Medical Equipment Section |
| | Hospice services | 30% coinsurance | 50% coinsurance | --------none-------- |
| **If your child needs dental or eye care** | Children's eye exam | 30% coinsurance | 50% coinsurance | *See Vision Services section |
| | Children's glasses | Not covered | Not covered | |
| | Children's dental check-up | Not covered | Not covered | --------none-------- |

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/aso.

## 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.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Pediatric)
- Dental Check-up
- Glasses for a child
- Infertility treatment
- Long-term care
- Routine foot care
- 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 24 visits/benefit period
- Hearing aids 1 Item/ear every 3 years, $2,500 maximum/benefit period
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Private-duty nursing 82 visits/benefit period and 164 visits/lifetime Facility Setting only
- Routine eye care (Adult)

**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: Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300, Columbus, Ohio 43215, (800) 686-1526, (614) 644-2673, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, 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:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

**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.

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

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/aso.

## 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 | $4,000 |
| Specialist *coinsurance* | 30% |
| Hospital (facility) *coinsurance* | 30% |
| Other *coinsurance* | 30% |

**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 | $4,000 |
| Copayments | $0 |
| Coinsurance | $2,400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$6,410** |

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

| | |
|---|---|
| The plan's overall deductible | $4,000 |
| Specialist *coinsurance* | 30% |
| Hospital (facility) *coinsurance* | 30% |
| Other *coinsurance* | 30% |

**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 | $4,000 |
| Copayments | $0 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$4,420** |

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

| | |
|---|---|
| The plan's overall deductible | $4,000 |
| Specialist *coinsurance* | 30% |
| Hospital (facility) *coinsurance* | 30% |
| Other *coinsurance* | 30% |

**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 | $2,800 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,800** |

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