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?	$2,500 for an individual and $5,000 for a family in-network; $5,000 for an individual and $10,000 for a family out-of-network	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 services in-network and items in which a copayment applies 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?	$5,500 for an individual and $11,000 for a family in-network; unlimited out-of-network	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, 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 www.ohioppoconnect.com or call 740-455-5199 for a list of network providers. For those who live outside Ohio see www.multiplan.com or call 800-922-4362.	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
		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	$25 copayment/office visit; deductible does not apply	40% coinsurance	If office visit is billed, in-network services provided during such visit are covered at no charge after the applicable copayment. If no office visit is charged, in-network office-based services are subject to 20% coinsurance after the deductible.
	Specialist visit	$50 copayment/office visit; deductible does not apply	40% coinsurance	
	Preventive care/screening/ immunization	No charge	50% coinsurance	Routine hearing exams and visual acuity screening through age 21. Mammogram and pap smear limited to 1 per calendar year. Colonoscopy, colorectal screenings, Cologuard testing and sigmoidoscopy for ages 40-75. Tobacco cessation limited to ages 18 and older. 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)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at **mbaccess.medben.com** (select MedBen Access).

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available through Ventegra, contact MedBen's Customer Service Department at 1-800-686-8425.	Generic drugs (Tier 1)	$20 copayment through retail; $40 copayment through mail order	Not covered except through retail/mail order	No charge for female contraceptives, tobacco cessation products, Tamoxifen & Raloxifene, generic statins, shingles (age 50 & older) & flu shots, bowel preparatory kits, and other preventive care drugs. See plan for listing. Covers up to a 30-day supply under retail and 90 day supply under mail order. All specialty drugs require a prior authorization.
	Preferred brand drugs (Tier 2)	$40 copayment through retail; $80 copayment through mail order	Not covered except through retail/mail order	
	Non-preferred brand drugs (Tier 3)	$80 copayment through retail; $160 copayment through mail order	Not covered except through retail/mail order	
	Specialty drugs (Tier 4)	30% coinsurance up to a maximum of$250 through retail ($500 through mail order)	Not covered except through retail/mail order	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Pre-certification required. Covered expenses are reduced by 50% to a maximum of $500 if not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$200 copayment; deductible does not apply	Paid at in-network level if emergency	Non-Emergency room care out-of-network is subject to a $200 copayment then 40% coinsurance, deductible does not apply.
	Emergency medical transportation	20% coinsurance	40% coinsurance	Includes air ambulance
	Urgent care	$50 copayment ; deductible does not apply	40% coinsurance	None

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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-certification required. Covered expenses are reduced by 50% to a maximum of $500 if not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment/office visit; deductible does not apply; 20% coinsurance for other outpatient services	40% coinsurance	Office visits include counseling services. Pre-certification required for inpatient services. Covered expenses are reduced by 50% to a maximum of $500 if not obtained.
	Inpatient services	Paid like other illnesses	Paid like other illnesses	
If you are pregnant	Office visits	$25 copayment; deductible does not apply	Paid like other illnesses	Pre-certification required after 48 hours following vaginal delivery or 96 hours following c-section. Covered expenses are reduced by 50% to a maximum of $500 if not obtained.
	Childbirth/delivery professional services	Paid like other illnesses	Paid like other illnesses	
	Childbirth/delivery facility services	Paid like other illnesses	Paid like other illnesses	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	60 visits per calendar year
	Rehabilitation services	20% coinsurance	40% coinsurance	Autism services are covered up to age 14. Clinical therapeutic intervention is limited to 20 hours per week. Speech and occupational therapy related to autism are limited to 20 visits per calendar year.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	100 days per calendar year. Pre-certification required for services. Covered expenses are reduced by 50% to a maximum of $500 if not obtained.
	Durable medical equipment	20% coinsurance	40% coinsurance	Wigs after cancer treatment 1 per lifetime. Bras after mastectomy 4 per calendar year.

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)	
	Hospice services	20% coinsurance	40% coinsurance	180 days per calendar year. Pre-certification required for inpatient services. Covered expenses are reduced by 50% to a maximum of $500 if not obtained.
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	If included in preventive care recommendations, through age 21
	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.)

- Acupuncture;
- Bariatric surgery
- Cosmetic surgery;
- Dental care (Adult)- accidental dental is covered up to 1 year after the accident and medically necessary hospitalization in connection with dental procedures;
- Hearing aids and implants and other devices to help restore hearing;
- Infertility treatment-all testing up to diagnosis and corrections of defects preventing pregnancy are covered;
- Long-term care;
- Non-emergency care when traveling outside the U.S;
- Routine eye care (Adult);
- Routine foot care-except for those with peripheral vascular disease or circulatory issues; 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, limited to 35 visits per calendar year;
- Dialysis services – out-of-network services pay at in-network level and are payable up to the Medicare allowable rate; and
- 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 those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: MedBen's Customer Service Department at 1-800-686-8425, mbaccess.medben.com (select MedBen Access) or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may be available in your state to help you file your appeal. 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.**
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 1-800-862-6704.

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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	$2,500
Specialist copayment	$50
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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$700
The total Peg would pay is	**$5,010**

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

The plan's overall deductible	$2,500
Specialist copayment	$50
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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$200
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,500**

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

The plan's overall deductible	$2,500
Specialist copayment	$50
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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,600
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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