

Coverage for: Employee, Family | Plan Type: PPO



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, [www.healthscopebenefits.com](http://www.healthscopebenefits.com). 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.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-888-249-8247 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<a href="#">Network</a> : \$100 Employee, \$200 Family; <a href="#">Non-network</a> : \$100 Employee, \$200 Family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes, <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	No	Not applicable; There is no <a href="#">out-of-pocket limit</a> on your expenses.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Premiums, penalties, amounts over Usual and Customary fees and excluded charges.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.frontpathcoalition.net">www.frontpathcoalition.net</a>	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No. You don't need a referral to see a <a href="#">specialist</a> .	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$10 <a href="#">copay</a>	\$10 <a href="#">copay</a>	Services subject to the Office Visit Rider Benefit are subject to <a href="#">copay</a> then payable at 100% <a href="#">Network</a> and 80% <a href="#">Non-network</a> until the rider is exhausted (\$300 Individual and \$600 Family). Benefits are then subject to <a href="#">deductible</a> and <a href="#">coinsurance</a> .  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.
	<a href="#">Specialist</a> visit	\$10 <a href="#">copay</a>	\$10 <a href="#">copay</a>	
	<a href="#">Preventive care/screening/immunization</a>	No Charge	20% <a href="#">coinsurance</a>	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge (Outpatient)	20% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	No Charge	20% <a href="#">coinsurance</a>	<a href="#">Precertification</a> required for MRI.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>	Generic drugs	Not Covered	Not Covered	Prescriptions are provided through OptumRX. Please call 1-855-872-5396 for assistance.
	Preferred brand drugs	Not Covered	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	<a href="#">Specialty drugs</a>	Not Covered	Not Covered	Specialty drugs are provided through OptumRX at 1-855-872-5396.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	20% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a>	\$200 <a href="#">copay</a> 20% <a href="#">coinsurance</a>	The plan does not cover the ER visit room charge in case of non-emergency. <a href="#">Copay</a> waived if admitted to hospital.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Urgent care</a>	\$10 <a href="#">copay</a>	\$10 <a href="#">copay</a>	None

\* For more information about limitations and exceptions, see the plan or policy document at [www.healthscopebenefits.com](http://www.healthscopebenefits.com).

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)	
			20% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Inpatient services	No charge	20% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required
If you are pregnant	Office visits	No charge	20% <a href="#">coinsurance</a>	None
	Childbirth/delivery professional services	No charge	20% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	No charge	20% <a href="#">coinsurance</a>	<a href="#">Precertification</a> required for confinement exceeding 48 hours for routine vaginal delivery and 96 hours for cesarean section delivery.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	20% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required
	<a href="#">Rehabilitation services</a>	Inpatient: No charge Outpatient: 20% <a href="#">coinsurance</a>	Inpatient: 20% <a href="#">coinsurance</a> Outpatient: 40% <a href="#">coinsurance</a>	None
	<a href="#">Habilitation services</a>	Inpatient: No charge Outpatient: 20% <a href="#">coinsurance</a>	Inpatient: 20% <a href="#">coinsurance</a> Outpatient: 40% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	No charge	20% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required
	<a href="#">Durable medical equipment</a>	Inpatient: No charge Outpatient: 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Inpatient: 20% <a href="#">coinsurance</a> Outpatient: 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Hospice services</a>	No charge	0% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Please contact your union at 419-536-0880 between 9 am and 1 pm, Monday thru Friday.

\* For more information about limitations and exceptions, see the plan or policy document at [www.healthscopebenefits.com](http://www.healthscopebenefits.com).

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	Please contact your union at 419-536-0880 between 9 am and 1 pm, Monday thru Friday.
	Children's dental check-up	Not Covered	Not Covered	Please contact Delta Dental at 1-800-524-0149

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic Surgery</li> <li>Dental Care</li> <li>Hearing Aids</li> </ul>	<ul style="list-style-type: none"> <li>Infertility Treatment</li> <li>Long Term Care</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Routine Foot Care</li> <li>Weight Loss Programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Bariatric Surgery (When recommended by physician; lifetime maximum benefit \$15,000)</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic Care</li> </ul>	<ul style="list-style-type: none"> <li>Private Duty Nursing</li> </ul>

**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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272. 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](http://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: HealthSCOPE Benefits at 1-888-249-8247.

### 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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-249-8247.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-249-8247.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-249-8247.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-888-249-8247.

*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 in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$10
- [Hospital \(facility\) coinsurance](#) 0%
- 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$20
Coinsurance	\$2,008
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,188</b>

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$10
- [Hospital \(facility\) coinsurance](#) 0%
- 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$100
Coinsurance	\$1,224
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,479</b>

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$10
- [Hospital \(facility\) coinsurance](#) 0%
- 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*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$280
Coinsurance	\$283
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$663</b>