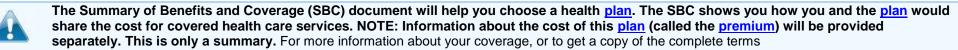
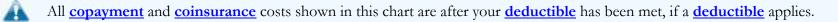
OHI dba Northern Buckeye Health Plan: Access+ PPO



of coverage, <u>https://eoc.anthem.com/eocdps/aso</u>. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <u>www.healthcare.gov/sbc-glossary/</u> or call (855) 825-1125 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$1,000/person or \$2,000/family for In- <u>Network Providers</u> . \$1,000/person or \$2,000/family for Non- <u>Network</u> <u>Providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible?</u>	Yes. Primary Care. <u>Specialist</u> Visit. <u>Preventive Care</u> . Vision. For more information see below.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$3,750/person or \$7,500/family for In- <u>Network Providers</u> . \$4,350/person or \$8,700/family for Non- <u>Network</u> <u>Providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Pre-Authorization Penalties, Premiums, balance-billing charges, health care this plan doesn't cover, and Non- <u>Network</u> Transplants.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
	Copays for certain specialty prescription drugs considered non- essential health benefits under the plan. The copays for these drugs (though manufacturer copay assistance programs may support some fills at no remaining cost to you) will not apply towards satisfying your out-of-pocket maximum or any applicable deductible.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes, Blue Access. See <u>www.anthem.com</u> or call (855) 825-1125 for a list of <u>network providers</u> . Costs may vary by site of service and how the provider bills.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



		What You			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	\$30/visit <u>deductible</u> does not apply	40% coinsurance	Virtual visits (Telehealth) benefits available.	
If you visit a health care	Specialist visit	\$60/visit <u>deductible</u> does not apply	40% coinsurance	Virtual visits (Telehealth) benefits available.	
provider's office or clinic	Preventive care/screening/ immunization	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	none	
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	none	
	Tier 1 - Typically Generic	\$15/prescription (retail) and \$30/prescription (home delivery)	\$15/prescription (retail) and Not covered (home delivery)	Once the Out-of-Pocket maximum has been met, prescription drug shall be	
	Tier 2 - Typically Preferred Brand & Non- Preferred Generic Drugs	\$45/prescription (retail) and \$90/prescription (home delivery)	\$45/prescription (retail) and Not covered (home delivery)	covered at 100% for the remainder of the calendar year.	
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	\$85/prescription (retail) and \$170/prescription (home delivery)	\$85/prescription (retail) and Not covered (home delivery)	Covers up to a 34-day supply (retail prescription); 90-day supply (mail orders	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com.	Tier 4 - Typically Preferred Specialty (brand and generic)	\$100/prescription (retail) and \$200/prescription (home delivery)	\$100/prescription (retail) and Not covered (home delivery)	 or Smart90 retail prescription). Certain prescriptions shall be covered at 100%, and no co-pay will apply as per Federal Regulations. Patient must pay the cost difference between the brand and generic drug in addition to your copay or coinsurance. * Copays for certain specialty prescription drugs considered non- essential health benefits under the plan bypass your out-of-pocket limit. Please see "Important Questions" regarding the plan's out- of-pocket limit. See Plan Documents for additional information on the SaveonSP Program. Out-of-Network RX reimbursed at 100% minus applicable copayment by filing RX claim form. 	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	none	
surgery	Physician/surgeon fees	20% coinsurance	40% coinsurance	none	
	Emergency room care	\$250/visit <u>deductible</u> does not apply	Covered as In- <u>Network</u>	Copay waived if admitted.	
If you need immediate	Emergency medical transportation	20% coinsurance	Covered as In- <u>Network</u>	none	
medical attention	Urgent care	\$60/visit <u>deductible</u> does not apply	Within 72 hours of onset: No charge after <u>deductible</u> ; After 72 hours: 40% <u>coinsurance</u>	none	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% <u>coinsurance</u>	Services must be pre-certified in order to avoid a 50% penalty up to a maximum penalty of \$500 per occurrence.	
-	Physician/surgeon fees	20% coinsurance	40% coinsurance	none	

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

Common		What You	Limitations Excentions & Other		
Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	 Limitations, Exceptions, & Other Important Information 	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$30/visit <u>deductible</u> does not apply Other Outpatient 20% <u>coinsurance</u>	Office Visit 40% <u>coinsurance</u> Other Outpatient 40% <u>coinsurance</u>	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient none	
	Inpatient services	20% coinsurance	40% <u>coinsurance</u>	none	
If you are pregnant	Office visits Childbirth/delivery professional services Childbirth/delivery facility services	\$30/visit <u>deductible</u> does not apply 20% <u>coinsurance</u> 20% <u>coinsurance</u>	40% <u>coinsurance</u> 40% <u>coinsurance</u> 40% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	
	Home health care	20% coinsurance	40% coinsurance	none	
If you need help	Rehabilitation services Habilitation services	\$30/visit <u>deductible</u> does not apply \$30/visit <u>deductible</u> does not apply	40% <u>coinsurance</u> 40% <u>coinsurance</u>	*See Therapy Services section.	
recovering or have other special health needs	Skilled nursing care	20% coinsurance	40% coinsurance	60 days/benefit period for skilled nursing services.	
neeus	Durable medical equipment	20% coinsurance	40% coinsurance	*See Durable Medical Equipment Section	
	Hospice services	20% coinsurance	40% coinsurance	Patient's life expectancy is 6 months or less.	
If your child needs dental or eye care	Children's eye exam Children's glasses	No charge Not covered	40% <u>coinsurance</u> Not covered	*See Vision Services section	
demai of cyc care	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 Dental care (Pediatric) Hearing aids Routine foot care 	 Cosmetic surgery Dental Check-up Long-term care Weight loss programs 	 Dental care (Adult) Glasses for a child Routine eye care (Adult) 				
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)						

٠	Bariatric surgery	•	Chiropractic care 62 visits/benefit period combined	•	Infertility treatment (except promotion of conception)
٠	Most coverage provided outside the United States. See www.bcbsglobalcore.com		with all other therapies Private-duty nursing in a Home Setting only		
	www.bcbsglobacorc.com	•	Thvate-duty huising in a frome setting only		

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, or contact Anthem at the number on the back of your ID card. 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:

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

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

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, Medicare, Medicare, Medicare, 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 <u>plan</u> might cover costs for a sample medical situation, see the next section.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost</u> <u>sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal car hospital delivery)	re and a	Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well- controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)		
 The <u>plan's</u> overall <u>deductible</u> <u>Specialist</u> <u>copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$1,000 \$60 20% 20%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist</u> <u>copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$1,000 \$60 20% 20%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist</u> <u>copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$1,000 \$60 20% 20%	
This EXAMPLE event includes servi like: <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Service Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood wo</i> <u>Specialist</u> visit (<i>anesthesia</i>)	°S	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)		This EXAMPLE event includes services like: <u>Emergency room care</u> (including medical supplies) <u>Diagnostic test</u> (x-ray) <u>Durable medical equipment</u> (crutches) <u>Rehabilitation services</u> (physical therapy)		
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800	
In this example, Peg would pay: <u>Cost Sharing</u>		In this example, Joe would pay: <u>Cost Sharing</u>		In this example, Mia would pay: <u>Cost Sharing</u>		
Deductibles	\$1,000	Deductibles	\$1,000	Deductibles	\$1,000	
Copayments	\$0	<u>Copayments</u>	\$400	<u>Copayments</u>	\$340	
Coinsurance	\$2,340	Coinsurance	\$1,000	Coinsurance \$		
What isn't covered		What isn't covered		What isn't covered		
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0	
The total Peg would pay is	\$3,400	The total Joe would pay is	\$2,420	The total Mia would pay is	\$1,632	

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 825-1125

Amharic (አጣርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማና7ር (855) 825-1125 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 1125-825 (855) .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվձար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով։ Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 825-1125։

Bassa (Băsóð Wùdù): M dyi dyi-diè-dè bě bédé bá céè-dè nìà kɛ dyí ní, ɔ mò nì dyí-bèdèìn-dè bé m ké gbo-kpá-kpá kè bỗ kpõ dé m bídí-wùdùǔn bó pídyi. Bé m ké wudu-zììn-nyò dò gbo wùdù kɛ, dá (855) 825-1125.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, ভাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা ব্লার জন্য (855) 825-1125 –তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (855) 825-1125 သို့ ခေါ် ဆိုပါ။

Chinese (中文):如果您對本文件有任何疑問,您有權使用您的語言免費獲得協助和資訊。如需與譯員通話,請致電(855) 825-1125。

Dinka (Dinka): Na noŋ thiëëc në ke de yä thorë, ke yin noŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kor yin ba jam wënë ran ye thok geryic, ke yin col (855) 825-1125.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 825-1125.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینهای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 825-125 (855) تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 825-1125.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 825-1125.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 825-1125.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (855) 825-1125.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 825-1125.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें(855) 825-1125 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855) 825-1125.

Igbo (Igbo): O bụr ụ na į nwere ajujų o bula gbasara akwukwo a, į nwere ikike inweta enyemaka na ozi n'asusu gi na akwughi ugwo o bula. Ka gi na okowa okwu kwuo okwu, kpoo (855) 825-1125.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (855) 825-1125.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (855) 825-1125.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 825-1125

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには. (855) 825-1125 にお電話ください。

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