OHI dba Northern Buckeye Health Plan: Advantage 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) 825-1125 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,200/person or $5,000/family for In-Network Providers. $3,200/person or $6,000/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 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. Vision. For more information see below.	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?	$4,500/person or $7,700/family for In-Network Providers. $5,000/person or $9,000/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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
	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 out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, Blue Access. See www.anthem.com or call (855) 825-1125 for a list of network providers. Costs may vary by site of service and how the provider bills.	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	20% coinsurance	30% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	20% coinsurance	30% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	No charge	30% 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)	20% coinsurance	30% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	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 covered at 100% for the remainder of the calendar year. Covers up to a 34-day supply (retail prescription); 90-day supply (mail orders 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
	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)	
	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)	
	Tier 4 - Typically Preferred Specialty (brand and generic)	$100/prescription (retail) and $200/prescription (home delivery)	$100/prescription (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	--------none--------
	Physician/surgeon fees	20% coinsurance	30% coinsurance	--------none--------
	Emergency room care	20% coinsurance	Covered as In-Network	--------none--------

* 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		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	Covered as In-Network	--------none--------
	Urgent care	20% coinsurance	30% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	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	30% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 20% coinsurance Other Outpatient 20% coinsurance	Office Visit 30% coinsurance Other Outpatient 30% coinsurance	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient --------none--------
	Inpatient services	20% coinsurance	30% coinsurance	--------none--------
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	--------none--------
	Rehabilitation services	20% coinsurance	30% coinsurance	*See Therapy Services section.
	Habilitation services	20% coinsurance	30% coinsurance	
	Skilled nursing care	20% coinsurance	30% coinsurance	60 days/benefit period for skilled nursing services.
	Durable medical equipment	20% coinsurance	30% coinsurance	*See Durable Medical Equipment Section
	Hospice services	20% coinsurance	30% coinsurance	Patient's life expectancy is 6 months or less.
If your child needs dental or eye care	Children's eye exam	No charge	30% coinsurance	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	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
- Cosmetic surgery
- Dental care (Adult)

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

- Dental care (Pediatric)
- Hearing aids
- Routine foot care
- Dental Check-up
- Long-term care
- Weight loss programs
- 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 plan document.)

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

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 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

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	$3,200
Specialist *coinsurance*	20%
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	$3,200
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,760**

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

The plan's overall deductible	$3,200
Specialist *coinsurance*	20%
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	$3,200
Copayments	$0
Coinsurance	$520
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,740**

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

The plan's overall deductible	$3,200
Specialist *coinsurance*	20%
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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

Language Access Services:

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html