



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://OhioWesleyan.myaptahealth.com> or call the Apta Care Coordinators at 1-866-274-9478. 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 the Apta Care Coordinators at 1-866-274-9478 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For network providers : \$1,000 person / \$2,000 family; for out-of-network providers \$2,000 person or \$4,000 family.	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 , prescription drugs , urgent care and primary care provider and specialist services, Teledoc, and children's eye exams 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 ?	For network providers \$3,500 person / \$7,000 family; for out-of-network providers \$7,000 person / \$14,000 family.	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 , Preauthorization penalty amounts, 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 https://OhioWesleyan.myaptahealth.com or call 1-800-343-3140 for a list of network providers in the Aetna Choice POS II Network	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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral , however, you will receive a higher benefit if a referral is obtained.

 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	\$20 copay / office visit	30% coinsurance	Copay applies per visit regardless of what services are rendered. Deductible does not apply for participating network providers . There is no copay if you receive video telemedicine services from Teladoc. See plan for further details.
	Specialist visit	\$40 copay / visit (with referral) \$80 copay / visit (without referral)	30% coinsurance	You will receive a higher benefit if a referral is obtained for a specialist visit.
	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. Deductible applies.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	Deductible applies.
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	Deductible applies. Preauthorization is required for PET Scans, MRI's, MRA's. Failure to obtain preauthorization will result in a \$500 penalty.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.primetherapeutics.com	Generic drugs (Tier 1)	\$10 copay (retail) / \$10 copay (mail order)	Not Covered	The deductible does not apply. Copay applies per prescription. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). No charge for ACA mandated preventive drugs and smoking deterrents. No charge for OTC acid reflux medication or for allergies (with an Rx) from a retail pharmacy. Dispense
	Preferred brand drugs (Tier 2)	\$35 copay (retail) / \$70 copay (mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3)	\$70 copay (retail) / \$140 copay (mail order)	Not Covered	

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://OhioWesleyan.myaptahealth.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)	
	Specialty drugs (Tier 4)	25% coinsurance , \$250 Maximum	Not Covered	as Written (DAW) applies. Specialty drugs are limited to a 30-day supply (retail and mail-order). Specialty drugs must be obtained directly from the specialty pharmacy program after one fill at a retail pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	The deductible applies. Preauthorization required unless performed in an office setting. Failure to obtain preauthorization will result in a \$500 penalty.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	\$250 copay / 10% coinsurance	\$250 copay / 10% coinsurance	Deductible applies. Non-participating providers paid at the participating network provider level.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Deductible applies. Non-participating providers paid at the participating network provider level.
	Urgent care	\$75 copay per visit	30% coinsurance	Copay applies per visit regardless of what services are rendered, except for diagnostic testing, x-ray and lab services which are paid at 100%, Deductible waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Deductible applies. Preauthorization required. Failure to obtain preauthorization will result in a \$500 penalty.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	30% coinsurance	The deductible does not apply for participating network providers . There will not be copay and the deductible does not apply if you receive video telemedicine services from Teladoc.
	Inpatient services	10% coinsurance	30% coinsurance	Preauthorization required. Failure to obtain preauthorization will result in a \$500 penalty.
If you are pregnant	Office visits	No Charge (deductible waived) for preventive services . Other services	30% coinsurance	Preauthorization required for inpatient hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (C-section). Failure to obtain

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://OhioWesleyan.myaptahealth.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)	
		10% coinsurance .		preauthorization will result in a \$500 penalty. Baby does not count toward the mother's expense; therefore the family deductible amount may apply. Cost-sharing does not apply to preventive services from a participating provider. Depending on the type of services, a coinsurance and/or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Deductible applies. Limited to 120 visits per plan year. Preauthorization required. Failure to obtain preauthorization will result in a \$500 penalty.
	Rehabilitation services	10% coinsurance	30% coinsurance	Deductible applies. Includes physical, speech & occupational therapy. No limit.
	Habilitation services	Not Covered	Not Covered	This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD and to expenses covered as a preventive service .
	Skilled nursing care	10% coinsurance	30% coinsurance	Deductible applies. Limited to 60 days per plan year. Preauthorization required. Failure to obtain preauthorization will result in a \$500 penalty.
	Durable medical equipment	10% coinsurance	30% coinsurance	Deductible applies. Preauthorization required for any item in excess of \$1,500. Failure to obtain preauthorization will result in a \$500 penalty.
	Hospice services	10% coinsurance	30% coinsurance	Deductible applies. Bereavement counseling is covered if received within 6 months of death. Preauthorization is required. Failure to obtain preauthorization will result in a \$500 penalty.
If your child needs	Children's eye exam	No Charge	No Charge	Coverage limited to one exam/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)	
dental or eye care	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 & child) - Glasses (adult & child) - Infertility Treatment	- Long Term Care - Massage Therapy - Non-emergency care when traveling outside the U.S. (If you become sick or injured while traveling, the plan may cover expenses incurred up to 120 consecutive days. This 120-day time limit does not apply if you are traveling for business or are a student.)	- Private Duty Nursing (except for home health care & hospice) - 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	Routine eye care (Adult & Child)		

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 or <https://www.dol.gov/agencies/ebsa>. or 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:

The U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <https://www.dol.gov/agencies/ebsa>

Additionally, a consumer assistance program can help you file your appeal. Contact the Arkansas Insurance Department, Consumer Services Division at (800) 852-5494. California Consumer Assistance Program, operated by the California Department of Managed Health Care at (888) 466-2219. Connecticut Office of the Healthcare Advocate at (866) 466-4446. Delaware Department of Insurance at (800) 282-8611. Delaware Department of Insurance at (800) 282-8611. DC Office of the Health Care Ombudsman and Bill of Rights at (877) 685-6391. Georgia Office of Insurance and Safety Fire Commissioner at (800) 656-2298.

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://OhioWesleyan.myaptahealth.com>

Guam Department of Revenue and Taxation at (671) 635-1846.
Illinois Department of Insurance at (877) 527-9431.
Kansas Insurance Department, Consumer Assistance Division at (800) 432-2484 (in state)/ (785) 296.
Kentucky Department of Insurance, Consumer Protection Division at (800) 595-6053.
Maine Consumers for Affordable Health Care at (800) 965-7476.
Maryland Office of the Attorney General, Health Education and Advocacy Unit at (877) 261-8807.
Massachusetts Health Care For All at (800) 272-4232.
Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Department of Insurance and Financial Services (DIFS) at (877) 999-6442.
(Mississippi) Health Help Mississippi at (877) 314-3843.
Missouri Department of Insurance at (800) 726-7390.
Office of the Montana State Auditor, Commissioner of Securities & Insurance at (800) 332-6148.
Nevada Office of Consumer Health Assistance, Governor's Consumer Health Advocate at (888) 333-1597.
New Hampshire Department of Insurance at (800) 852-3416.
New Jersey Department of Banking and Insurance at (800) 446-7467 or (609) 292-7272.
New Mexico Public Regulation Commission, Consumer Relations Division at (855) 857-0972 or (888) 427-5772.
Community Service Society of New York, Community Health Advocates at (888) 614-5400.
North Carolina Department of Insurance, Health Insurance Smart NC at (855) 408-1212.
Oklahoma Insurance Department at (800) 522-0071.
Oregon Health Connect at (866) 698-6155.
Pennsylvania Insurance Department at (877) 881-6388.
Puerto Rico Oficina de la Procuradora del Paciente at (787) 979-0909.
Rhode Island Consumer Assistance Program, Rhode Island Parent Information Network, Inc. at (855) 747-3224.
South Carolina Department of Insurance, Consumer and Individual Licensing Services at (800) 768-3467.
Tennessee Department of Commerce & Insurance at (615) 741-2241.
Texas Consumer Health Assistance Program, Texas Department of Insurance at (855) 839-2427 (855-TEX-CHAP).
Vermont Legal Aid at (800) 889-2047.
Virginia State Corporation Commission, Life & Health Division, Bureau of Insurance at (877) 310-6560.U.S.
U.S. Virgin Islands Division of Banking and Insurance at (340) 773-6459.
Washington Consumer Assistance Program at (800) 562-6900.
West Virginia Offices of the Insurance Commissioner, Consumer Service Division at (888) 879-9842.

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 800-378-1179.

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://OhioWesleyan.myaptahealth.com>

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-378-1179.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 800-378-1179.

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	\$1,000
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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*	\$1000
Copayments	\$10
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,070

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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*	\$800
Copayments	\$800
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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*	\$1,000
Copayments	\$400
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,500

*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.