




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.mycarefactor.com](http://www.mycarefactor.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.mycarefactor.com](http://www.mycarefactor.com) or call 614-766-5800 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$250 /individual or \$500/ family Out-of-network: \$500/individual or \$1,000/family	Generally, you must pay all of the costs from <a href="#">providers</a> 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are 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> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$25 individual / \$75 family for dental, if elected.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$600 individual/\$1,200 family; for <a href="#">out-of-network</a> providers \$1,000 individual / \$2,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Non- Precertification Penalties, Amounts over Usual and Reasonable.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.mycarefactor.com">www.mycarefactor.com</a> or call 1-614-766-5800 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's 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 <a href="#">provider's</a> 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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

**Questions:** Call 614-766-5800 or visit us at [www.mycarefactor.com](http://www.mycarefactor.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> and 0% <a href="#">coinsurance</a>	\$45 <a href="#">copay</a> and 40% <a href="#">coinsurance after deductible</a>	None
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a> and 0% <a href="#">coinsurance</a>	\$45 <a href="#">copay</a> and 40% <a href="#">coinsurance after deductible</a>	
	<a href="#">Preventive care/screening/immunization</a>	No Charge	No Charge	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance after deductible</a>	40% <a href="#">coinsurance after deductible</a>	
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance after deductible</a>	40% <a href="#">coinsurance after deductible</a>	
	COVID- 19	No Charge	No Charge	Out-of-Network will be paid at the Usual, Reasonable, and Customary rate
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.magellanrx.com">www.magellanrx.com</a>	Generic drugs (Tier 1)	\$10 <a href="#">copay</a> and 0% <a href="#">coinsurance</a>	\$25 <a href="#">copay</a> and 0% <a href="#">coinsurance</a>	Mail order Copays: \$20/\$40/\$60
	Preferred brand drugs (Tier 2)	\$20 <a href="#">copay</a> and 0% <a href="#">coinsurance</a>	\$20 <a href="#">copay</a> and 0% <a href="#">coinsurance</a>	
	Non-preferred brand drugs (Tier 3)	\$30 <a href="#">copay</a> and 0% <a href="#">coinsurance</a>	\$30 <a href="#">copay</a> and 0% <a href="#">coinsurance</a>	
	<a href="#">Specialty drugs</a> (Tier 4)	May be available through the Select Drugs and Products Program	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance after deductible</a>	40% <a href="#">coinsurance after deductible</a>	
	Physician/surgeon fees	20% <a href="#">coinsurance after deductible</a>	40% <a href="#">coinsurance after deductible</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.mycarefactor.com.com](http://www.mycarefactor.com.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)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$75 <a href="#">copay</a> and 0% <a href="#">coinsurance</a>	\$75 <a href="#">copay</a> and 0% <a href="#">coinsurance</a>	Emergency room copayment waived if the
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance after deductible</a>	\$45 <a href="#">copay</a> and 40% <a href="#">coinsurance after deductible</a>	
	<a href="#">Urgent care</a>	\$35 <a href="#">copay</a> and 0% <a href="#">coinsurance</a>	\$30 <a href="#">copay</a> and 0% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance after deductible</a>	40% <a href="#">coinsurance after deductible</a>	
	Physician/surgeon fees	20% <a href="#">coinsurance after deductible</a>	40% <a href="#">coinsurance after deductible</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance after deductible</a>	40% <a href="#">coinsurance after deductible</a>	
	Inpatient services	20% <a href="#">coinsurance after deductible</a>	40% <a href="#">coinsurance after deductible</a>	
If you are pregnant	Office visits	\$25 <a href="#">copay</a> and 0% <a href="#">coinsurance</a>	\$45 <a href="#">copay</a> and 40% <a href="#">coinsurance after deductible</a>	
	Childbirth/delivery professional services	20% <a href="#">coinsurance after deductible</a>	40% <a href="#">coinsurance after deductible</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance after deductible</a>	40% <a href="#">coinsurance after deductible</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance after deductible</a>	40% <a href="#">coinsurance after deductible</a>	
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance after deductible</a>	40% <a href="#">coinsurance after deductible</a>	
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance after deductible</a>	40% <a href="#">coinsurance after deductible</a>	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance after deductible</a>	40% <a href="#">coinsurance after deductible</a>	
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance after deductible</a>	40% <a href="#">coinsurance after deductible</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.mycarefactor.com.com](http://www.mycarefactor.com.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)	
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance after deductible</a>	40% <a href="#">coinsurance after deductible</a>	
If your child needs dental or eye care	Children's eye exam	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	1 exam per calendar year
	Children's glasses	N/A	N/A	
	Children's dental check-up	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	2 per calendar year if dental elected.

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Acupuncture</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Hearing Aids</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>• Dental Care (Adult)</li> <li>• Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care(15 visits)</li> <li>• Private-Duty Nursing (30 visits per calendar year maximum)</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: You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](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 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: [www.mycarefactor.com](http://www.mycarefactor.com) or by calling 614-766-5800.

**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:

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

Spanish (Español): Para obtener asistencia en Español, llame al 614-766-5800

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 614-766-5800

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 614-766-5800

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 614-766-5800.

*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](#) \$250
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 0%

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>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,490
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,740</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$0
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a> *	\$250
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1070
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,320</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$0
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a> *	\$250
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$510
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$760</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert].

\*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.