**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services Coverage Period: 01/01/2025- 12/31/2025**

**Bowling Green State University : Plan B Coverage for:** 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, call 800-315-3137. 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 MedMutual.com/SBC or call 800-315-3137 to request a copy.

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| **Important Questions** | | | **Answers** | | | **Why This Matters:** | | | | | | | | |
| **What is the overall deductible?** | | | **$4,000**/family Network **$8,000**/family  Non-Network | | | 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 policy, the overall family  **deductible** must be met before the **plan** begins to pay. | | | | | | | | |
| **Are there services covered before you meet your deductible?** | | | **Yes. Certain preventive care and all services with copayments are covered and paid by the plan 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 service**s at [https://www.healthcare.gov/coverage/preventive-care-benefits/](http://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?** | | | **$6,750**/individual Network, **$8,000**/family Network, **$16,000**/family  Non-Network | | | 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**, the overall family **out-of-pocket** limit must be met. | | | | | | | | |
| **What is not included in the out-of-pocket limit?** | | | **Premiums**, balance-billed 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 MedMutual.com/SBC or call  800-315-3137 for a list of participating providers. | | | 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 **coinsurance** costs shown in this chart are after your  **deductible** has been met, if a **deductible** applies. Services with  **copayments** are covered before you meet your **deductible**, unless otherwise specified. | | | | | | | | | | | |
| **Common Medical Event Services You May Need What You Will Pay Limitations, Exceptions, & Other**  **Important Information a Network Provider a Non-Network Provider**  **(You will pay the least) (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 | | 10% coinsurance | | | 40% coinsurance | | None | |
| Specialist visit | | 10% coinsurance | | | 40% coinsurance | | None | |
| Preventive care/ screening/  immunization | | No charge | | | Not Covered | | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. | |
| **If you have a test** | | | | Diagnostic test (x-ray) | | 10% coinsurance | | | 40% coinsurance | | None | |
| Diagnostic test (blood work) | | 10% coinsurance | | | 40% coinsurance | | None | |
| Imaging (CT/PET scans, MRIs) | | 10% coinsurance | | | 40% coinsurance | | None | |
| **If you need drugs to treat your illness or condition**  For more information about prescription drug coverage, call 800-522-8159 or visit [www.caremark.com](http://www.caremark.com) | | | | | Generic drugs (Tier 1) | | 10% coinsurance | | | 40% coinsurance | Retail – 30 days  Mail Order – 90 days | | |
| Preferred brand drugs (i.e. those drugs on the formulary – Tier 2) | | 10% coinsurance | | | 40% coinsurance | Retail – 30 days  Mail Order – 90 days | | |
|  | | | | | Non-preferred brand drugs (Tier 3) | | 10% coinsurance | | | 40% coinsurance | Retail – 30 days  Mail Order – 90 days | | |
|  | | | | | Miscellaneous or Life-Style drugs  (Tier 4) | | 10% coinsurance | | | 40% coinsurance | Retail – 30 days | | |
|  | | | | | Specialty drugs | | For injectable drugs to treat multiple sclerosis, cancer, etc. contact Caremark to learn if the drug is preferred or non-preferred | | |  | Not all prescriptions are covered and some may be subject to prior approval. Contact Caremark for details. | | |
| **If you have outpatient surgery** | | | | | Facility fee (e.g., ambulatory surgery center) | | | | 10% coinsurance | 40% coinsurance | | None | |
| Physician/surgeon fees (Outpatient) | | | | 10% coinsurance | 40% coinsurance | | None | |
| **If you need immediate medical attention** | | | Emergency room care | | | | 10% **coinsurance** | | | None | |
| Emergency medical transportation | | | | 10% **coinsurance** | | | None | |
| Urgent care | | | | 10% coinsurance | | 40% coinsurance | None | |

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| **Common Medical Event** | **Services You May Need** | **What You Will Pay**    **a Network Provider a Non-Network Provider**  **(You will pay the least) (You will pay the most)** | | **Limitations, Exceptions, & Other Important Information** |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 40% coinsurance | None |
| Physician/ surgeon fee (inpatient) | 10% coinsurance | 40% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Benefits paid based on corresponding medical benefits | | None |
| Inpatient services | Benefits paid based on corresponding medical benefits | | None |
|  | | | |
| **If you are pregnant** | Office visits | No charge | Not Covered | Cost sharing does not apply to certain preventive services. Depending on the type of services, copay, coinsurance 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 | 40% coinsurance | None |
| Childbirth/delivery facility services | 10% coinsurance | 40% coinsurance | None |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 40% coinsurance | None |
| Rehabilitation services (Physical  Therapy) | 10% coinsurance | 40% coinsurance | (60 visits per benefit period, combined with Occupational and Speech Therapy) |
| Habilitation services (Occupational  Therapy) | 10% coinsurance | 40% coinsurance | (60 visits per benefit period, combined with Physical and Speech Therapy) |
| Habilitation services (Speech  Therapy) | 10% coinsurance | 40% coinsurance | (60 visits per benefit period combined with Physical and Occupational Therapy) |
| Skilled nursing care | 10% coinsurance | 40% coinsurance | None |
| Durable medical equipment | 10% coinsurance | 40% coinsurance | None |
| Hospice services | 10% coinsurance | 40% coinsurance | None |
| **If your child needs dental or eye care** | Children's eye exam | No charge | Not Covered | None |
| Children's glasses | Not Covered | | Excluded Service |
| Children's dental check-up | Not Covered | | Excluded Service |

For more information about limitations and exceptions, see the Plan or policy document at MedMutual.com/SBC or you can access this information through BGSU’s on-line benefits portal.

**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

**•** Children's dental check-up

**•** Children's glasses

**•** Cosmetic Surgery

**•** Dental Care (Adult)

**•** Hearing Aids

**•** Infertility Treatment

**•** Long-Term Care

**•** Routine Eye Care (Adult)

**•** 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.)**

• Bariatric Surgery

• Chiropractic Care

• Non-emergency care when traveling outside the

U.S.

• Private-Duty Nursing

**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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call

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 your plan at

800-315-3137.

**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 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 sample medical situations, see the next section*----------------------------------- The coverage example numbers assume that the patient does not use an HRA or FSA. If you participate in an HRA or FSA and use it to pay for out-of-pocket expenses, then your costs may be lower.

**About these Coverage Examples:**

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| --- | --- | --- | --- | --- | --- | --- |
| **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) |  | **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) |  |

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| **•** **The plan's overall deductible** | **$4,000** | **•** | **The plan's overall deductible** | **$4,000** | **•** | **The plan's overall deductible** | **$4,000** |
| **•** **Specialist coinsurance** | **10%** | **•** | **Specialist coinsurance** | **10%** | **•** | **Specialist coinsurance** | **10%** |
| **•** **Hospital (facility) coinsurance** | **10%** | **•** | **Hospital (facility) coinsurance** | **10%** | **•** | **Hospital (facility) coinsurance** | **10%** |
| **•** **Other coinsurance** | **10%** | **•** | **Other 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*)

**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:** Emergency room care (*including medical supplies*) Diagnostic test (*x-ray*)

Durable medical equipment (*crutches*)

Rehabilitation services (*physical therapy*)

**Total Example Cost $12,800 Total Example Cost $7,400 Total Example Cost $1,900**

**In this example, Peg would pay: In this example, Joe would pay: In this example, Mia would pay:**

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $4,000 |
| Copayments | $0 |
| Coinsurance | $340 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$4,340** |

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $1,900 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,900** |

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| --- | --- |
| *Cost Sharing* | |
| Deductibles | $4,000 |
| Copayments | $0 |
| Coinsurance | $880 |
| *What isn’t covered* | |
| Limits or exclusions | $100 |
| **The total Peg would pay is** | **$4,980** |

The plan would be responsible for the other costs of these EXAMPLE covered services.