



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. See www.ohcementmasonsbenefits.org or call 1-330-779-8860. 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 or call 1-833-610-1799 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network : \$350 per individual, \$700 per family Out-of-Network : \$700 per individual, \$1,400 per family	Generally, you must pay all 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 deductible until the total amount of deductible expenses paid by all family members meets the overall deductible .
Are there services covered before you meet your deductible?	Yes. Network office visits for injury or illness, network preventive care , telemedicine visits, Minute Clinic (CVS retail clinic) visits, and prescription drugs are covered before you meet your deductible .	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply.
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?	Network : \$1,750 per individual, \$3,500 per family Out-of-Network : \$3,500 per individual, \$7,000 per 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?	Copays , premiums , balance billed charges, prescription drugs , 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 www.anthem.com or call 1-833-610-1799 for a list of network 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 [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 per visit. Deductible does not apply.	40% coinsurance of allowed amount	\$20 copay per visit for non-LiveHealth telehealth physician visits (copayments waived for Anthem LiveHealth telehealth physician visits); deductible does not apply. \$20 copay per visit for Minute Clinics (CVS retail clinics); deductible does not apply; diagnostic labs paid in full after copay is paid.
	Specialist visit	\$20 copay per visit. Deductible does not apply.	40% coinsurance of allowed amount	Acupuncture not covered. Chiropractic care covered is covered at 20% coinsurance in network and 40% coinsurance out-of-network; deductible applies; limit of 12 visits per calendar year combined in network and out-of-network.
	Preventive care/screening /immunization	No charge. Deductible does not apply.	40% coinsurance of allowed amount	None
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance of allowed amount	Effective August 1, 2022, charges from out-of-network providers rendered at an in-network facility will be covered at the in-network rate.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance of allowed amount	See Note above.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optum.com .	Generic Drugs and Brand Name Drugs	20% coinsurance (retail and mail order); deductible does not apply	You must submit claim for reimbursement of the amount the plan would have paid for the drug (retail or mail order) in network minus 20% coinsurance ; deductible does not apply	

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	20% coinsurance (retail and mail order); deductible does not apply	You must submit claim for reimbursement of the amount the plan would have paid for the drug (retail or mail order) in network minus 20% coinsurance ; deductible does not apply	<p>Retail: 34-day supply; Mail Order: 90-day supply. Over-the-counter drugs available only with a prescription.</p> <p>If a brand name drug is prescribed “Dispense as Written” and a generic equivalent is available, you pay the cost difference between the brand and generic drug plus 20% coinsurance.</p> <p>Your cost sharing does not count toward the out-of-pocket limit.</p> <p>Retail: 34-day supply; Mail Order: 90-day supply.</p> <p>If a brand name drug is prescribed “Dispense as Written” and a generic equivalent is available, you pay the cost difference between the brand and generic drug plus 20% coinsurance.</p> <p>Your cost sharing does not count toward the out-of-pocket limit.</p>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance of allowed amount	None
	Physician/surgeon fees (Outpatient)	20% coinsurance	40% coinsurance of allowed amount	None
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance of allowed amount	40% coinsurance applies for non-emergency medical conditions in ER. Effective August 1, 2022, the Plan will cover all emergency services at out-of-network Emergency Rooms at the in-network rate.
	Emergency medical transportation	20% coinsurance	40% coinsurance of allowed amount	Effective August 1, 2022, the Plan will cover all emergency air ambulance services at the in-network rate.
	Urgent care	20% coinsurance	40% coinsurance of allowed amount	None

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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance of allowed amount	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance of allowed amount	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance of allowed amount	None
	Inpatient services	20% coinsurance	40% coinsurance of allowed amount	None
If you are pregnant	Office visits	20% coinsurance	40% coinsurance of allowed amount	Coverage for subscriber and subscriber spouse only.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance of allowed amount	Coverage for subscriber and subscriber spouse only.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance of allowed amount	Coverage for subscriber and subscriber spouse only.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance of allowed amount	Limited to 40 visits per calendar year.
	Rehabilitation services	20% coinsurance	40% coinsurance of allowed amount	None
	Habilitation services	20% coinsurance	40% coinsurance of allowed amount	None
	Skilled nursing care	20% coinsurance	40% coinsurance of allowed amount	None
	Durable medical equipment (DME)	20% coinsurance	40% coinsurance of allowed amount	None
	Hospice services	20% coinsurance	40% coinsurance of allowed amount	None
If your child needs dental or eye care	Children's eye exam	One exam every 12 months; \$0 copay	Up to \$45 allowance	Dental and Vision Coverage is a voluntary program that you purchase through your Dollar Bank. Out-of-Network vision allowances vary by materials (lens/contacts). Coverage is not available if you decline dental and vision coverage at Open Enrollment.
	Children's glasses	One pair of lenses every 12 months; \$180 frame allowance & \$0 lens/frame copay	Up to \$70 frame allowance	
	Children's dental check-up	100%	100%	

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 (except for [reconstructive surgery](#) following mastectomy)
- Hearing aids
- Routine foot care
- Routine eye care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Long-term Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric Surgery
- Chiropractic care (limited to 12 visits per calendar year)
- Private-duty nursing (only for [home health care](#))
- [Out-of-network emergency services](#)
- [Out-of-network providers](#) at [in-network](#) facilities
- Air ambulance services
- Dental/Vision coverage (Child and Adult, if purchased at open enrollment)

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>. 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 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 [Plan](#) at 330-779-8860 or visit <https://www.ourbenefitoffice.com/ohcementmasons/Benefits/MedicalBenefits.aspx>. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 Services: Language Access Services: Um Helf in Deutsch zu greige, rull dei Anthem Sales Representative, Drupp Blan Sponsor odder die Member Service uff dei ID karate aa. (Pennsylvania Dutch)

—————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 network provider pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$350
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$350
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,410
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Peg would pay is	\$1,780

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$350
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (DME) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$120
<u>Copayments</u>	\$120
<u>Coinsurance</u>	\$860
<i>What isn't covered</i>	
Limits or exclusions	\$250
The total Joe would pay is	\$1,350

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (DME) (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$700
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,050