

IN-NETWORK AND OUT-OF-NETWORK COSTS FOR MEDICAL PLANS

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	Ohio Med PPO	Ohio Med HDHP
Annual Deductible	\$400 single, \$800 family in-network; \$800 single, \$1,600 family out-of-network.	\$2,000 single/\$4,000 family in-network \$4,000 single/\$8,000 family out-of-network
Your Copayments (Office Visits)	Primary care physician: \$30 in-network, \$50 out-of-network; Specialist: \$35 in-network; \$55 out-of-network. Outpatient office visit: \$30 in-network; \$50 out-of-network (balance billing applies).	80% after deductible in-network 60% after deductible out-of-network
Coinsurance	Medical: You pay 20%, plan pays 80% in-network; you pay 40%, plan pays 60% out-of-network. Behavioral Health: <ul style="list-style-type: none"> Outpatient out-of-network: 60% of contracted allowable amount after copayment (balance billing applies) Inpatient in-network: 80% after deductible Inpatient out-of-network: 60% after deductible, \$350 penalty if not preauthorized 	80% after deductible in-network 60% after deductible out-of-network
Your Out-of-Pocket Maximum	\$2,500 single, \$5,000 family in-network; \$5,000 single, \$10,000 family out-of-network. This deductible is combined with behavioral health.	\$3,500 single/\$7,000 family in-network \$7,000 single/\$14,000 family out-of-network
Behavioral Health	No day, annual or lifetime limits. Some benefit limits may apply: for details, visit das.ohio.gov/behavioralhealth , click the Summary Plan Descriptions tab and select the current summary plan.	Same as PPO

BENEFIT/SERVICE COVERAGE LEVELS

Chiropractic Care	<ul style="list-style-type: none"> Covered at 80% in-network; 60% out-of-network Unlimited visits (review required after 25 visits) 	80% after deductible in-network 60% after deductible out-of-network
Diagnostic, X-Ray and Lab Services	<ul style="list-style-type: none"> Covered at 80% in-network; 60% out-of-network 	80% after deductible in-network 60% after deductible out-of-network
Durable Medical Equipment	<ul style="list-style-type: none"> Covered at 80% in-network; 60% out-of-network 	80% after deductible in-network 60% after deductible out-of-network
Emergency Room	<ul style="list-style-type: none"> Covered at 80%; \$150 copay, which is waived if patient is admitted as inpatient; 60% out-of-network for non-emergency 	80% after deductible; 60% after deductible out-of-network for non-emergency
Immunizations	<ul style="list-style-type: none"> Most are covered at 100% in-network; 60% out-of-network 	Same as PPO
Maternity – Delivery	<ul style="list-style-type: none"> Covered at 80% in-network; 60% out-of-network 	80% after deductible in-network 60% after deductible out-of-network
Physical, Occupational, and Speech Therapy	<ul style="list-style-type: none"> Covered at 80% in-network; 60% out-of-network Unlimited visits (review required after 25 visits) Includes coverage for Autism Spectrum Disorder 	80% after deductible in-network 60% after deductible out-of-network
Preventive Exams and Screenings	<ul style="list-style-type: none"> Most preventive care covered at 100% in-network; 60% out-of-network Age restrictions may apply 	Same as PPO
Urgent Care	<ul style="list-style-type: none"> \$40 copay in-network; \$60 copay out-of-network Covered at 80% in-network; 60% out-of-network 	80% after deductible in-network 60% after deductible out-of-network

Non-network services: Plan pays 60% of Ohio Med PPO and Ohio Med HDHP contracted allowable amount and you pay any remaining balance (subject to balance billing).

If your out-of-network charge is greater than the contracted allowable amount, your out-of-pocket costs will be more.