

OHIO MED PPO (Bold denotes an improvement from the HMO plan design.)

OUT-OF-POCKET COSTS

Annual Deductible	Network: \$200 single, \$400 family; out of network: \$400 single, \$800 family.
Your Copayments (Office Visits)	Network: \$20; out of network: \$30.
Coinsurance	Network: You pay 20%, plan pays 80%; out of network: You pay 40%, plan pays 60%. ¹
Your Out-of-Pocket Maximum	Network: \$1,500 single, \$3,000 family; out of network: \$3,000 single, \$6,000 family. ²
BENEFIT/SERVICE	COVERAGE LEVELS
Chiropractic Care	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network. Unlimited visits.
Diagnostic, X-Ray and Lab Services	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network.
Durable Medical Equipment	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network.
Emergency Room	<ul style="list-style-type: none"> Covered at 80%; \$75 copay, which is waived if patient is admitted; 60% out of network for non-emergency.
Hearing Loss (Accidental, Injury or Illness)	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network. Exams and follow-ups are included in coverage. No lifetime maximum.
Home Health Care	<ul style="list-style-type: none"> Covered at 80% network; 60% out of network; limit of 100 visits or 180 days.
Hospice Services	<ul style="list-style-type: none"> Covered at 100% with no copay, time or dollar limitations. For both in and out of network.
Immunizations	<ul style="list-style-type: none"> Most are covered at 100% (see Page 9). For both in and out of network.
Infertility Testing	<ul style="list-style-type: none"> Covered at 80% after \$20 copay, for in network; 60% and \$30 copay out of network. Coverage includes testing only.
Inpatient and Outpatient Services	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network.
Maternity - Delivery	<ul style="list-style-type: none"> Covered at 80% in network; 60% out of network.
Maternity - Prenatal Care	<ul style="list-style-type: none"> Office visits covered at 100% when billed separately from delivery; tests/procedures covered at 80% in network; 60% 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.
Preventive Exams & Screenings	<ul style="list-style-type: none"> Most preventive care covered at 100% (see Preventive Care chart on Page 9). Age restrictions may apply.
Skilled Nursing Facility	<ul style="list-style-type: none"> Covered at 80%; 180-day limit, additional days covered at 60%, for both in and out of network.
Urgent Care	<ul style="list-style-type: none"> \$25 copay in network; \$30 copay out of network. Covered at 80% in network; 60% out of network.

¹ Plan pays 60% of Ohio Med's benefit allowance and you pay any remaining balance.

² If your non-network provider charge is greater than the Ohio Med PPO allowance, your out-of-pocket costs will be more.