

Ohio Med PPO

OUT-OF-POCKET COSTS

Annual Deductible	Network: \$200 single, \$400 family; out-of-network: \$400 single, \$800 family (combined with behavioral health).
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 ³	Network: \$1,500 single, \$3,000 family; out-of-network: \$3,000 single, \$6,000 family ² (combined with behavioral health).

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 as inpatient; 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.
Home Health Care	<ul style="list-style-type: none"> Covered at 80% in-network; 60% out-of-network; limit of 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% in-network; 60% out-of-network.
Infertility Testing	<ul style="list-style-type: none"> Covered at 80% after \$20 copay, for in-network; 60% after \$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/ Postpartum Care	<ul style="list-style-type: none"> Prenatal Care: Office visits covered at 100% when billed separately from delivery; tests/procedures covered at 80% in-network; 60% out-of-network. Postpartum Care: breast-feeding support and counseling (including lactation classes), and supplies (including breast pump rental) covered at 100%.
Physical, Occupational and Speech Therapy	<ul style="list-style-type: none"> Covered at 80% in-network; 60% out-of-network. Unlimited visits (review required). Includes coverage for Autism Spectrum Disorder.
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.
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 PPO's contracted allowable amount and you pay any remaining balance.

² If your out-of-network charge is greater than the Ohio Med PPO contracted allowable amount, your out-of-pocket costs will be more.

³ For prescription drug out-of-pocket cost information, visit das.ohio.gov/prescriptiondrug.