

Ohio Med Plan PPO Mental Health Program Benefit Changes Effective July 1, 2010

Changes are in bold print

| | PPO Benefits | UBH Benefit prior to 7/1/10 | UBH Benefit eff. 7/1/10 |
|------------------------------------|--|-----------------------------|--|
| DEDUCTIBLES | | | |
| Single in-network | \$200 | No deductible | \$200 combined with medical |
| Family in-network | \$400 | No deductible | \$400 combined with medical |
| Single out-of-network | \$400 | No deductible | \$400 combined with medical |
| Family out-of-network | \$800 | No deductible | \$800 combined with medical |
| OUT-OF-POCKET MAXIMUM | | | |
| Single in-network | \$1,500 | No out-of-pocket maximum | \$1,500 combined with medical |
| Family in-network | \$3,000 | No out-of-pocket maximum | \$3,000 combined with medical |
| Single out-of-network | \$3,000 | No out-of-pocket maximum | \$3,000 combined with medical |
| Family out-of-network | \$6,000 | No out-of-pocket maximum | \$6,000 combined with medical |
| PLAN COINSURANCE PERCENTAGE | | | |
| Office visit in-network | 100% after copay. 80% for some services | 100% after copay | 100% after copay |
| Office visit out-of-network | 60% of fee schedule after copay, balance billing applies | Not covered | 60% of fee schedule after copay, balance billing applies |
| Inpatient in-network | 80% after deductible | \$100 per admission | 80% after deductible |
| Inpatient out-of-network | 60% after deductible, \$350 penalty | Not covered | 60% after deductible, \$350 penalty |
| COPAYMENTS | | | |
| Outpatient in-network | \$20 | \$20 | \$20 |
| Outpatient out-of-network | \$30; balance billing applies | Not covered | \$30; balance billing applies |
| Preventive care copayment | 0 | Does not apply | Does not apply |
| Urgent Care copayment | \$25 | Does not apply | Does not apply |
| Emergency room copayment | \$75 | Does not apply | Does not apply |
| Intensive outpatient care | Not covered | \$100 per episode of care | \$20 per visit in-network; \$30 per visit out of network, balance billing applies |
| OTHER | | | |
| Day Limits | None | None | None |
| Annual Limits | None | None | None |
| Lifetime Limits | None | None | None |
| Benefit Limits | Some services | None | None |
| Preauthorization-outpatient | Required for some services | Required | Required for some services |
| Preauthorization-inpatient | Required | Required | Required |