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, intensive outpatient care: $20 in network; $30 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:** Outpatient in-network: 100% after office visit copay; 80% of other services; ▪ 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	▪ 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	▪ Covered at 80% in-network; 60% out-of-network	80% after deductible in-network 60% after deductible out-of-network
Durable Medical Equipment	▪ Covered at 80% in-network; 60% out-of-network	80% after deductible in-network 60% after deductible out-of-network
Emergency Room	▪ 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	▪ Most are covered at 100% in-network; 60% out-of-network	Same as PPO
Maternity – Delivery	▪ 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	▪ 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	▪ Most preventive care covered at 100% in-network; 60% out-of-network ▪ Age restrictions may apply	Same as PPO
Urgent Care	▪ $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.