

	OHIO PPO 500		OHIO PPO 1500		OHIO PPO 2500	
MEMBER BENEFITS	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Individual/Family	\$500/\$1,000	\$1,000/\$2,000	\$1,500/\$3,000	\$3,000/\$6,000	\$2,500/\$5,000	\$5,000/\$10,000
Coinsurance	20%	50%	20%	50%	20%	50%
Out-of-Pocket Maximum (includes deductible) Individual/Family	\$2,000/\$4,000	\$2,500/\$5,000	\$3,000/\$6,000	\$4,500/\$9,000	\$5,000/\$10,000	\$7,500/\$15,000
Lifetime Maximum*	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrician or Internist)	\$20 copay (Ded. Waived)	50%	\$25 copay (Ded. Waived)	50%	\$30 copay (Ded. Waived)	50%
Specialist Visit	\$30 copay (Ded. Waived)	50%	\$35 copay (Ded. Waived)	50%	\$40 copay (Ded. Waived)	50%
Hospital Admission	20%	50%	20%	50%	20%	50%
Outpatient Surgery	20%	50%	20%	50%	20%	50%
Emergency Room	\$100 copay (waived if admitted), coinsurance 20%	\$100 copay (waived if admitted), coinsurance 20%	\$100 copay (waived if admitted), coinsurance 20%	\$100 copay (waived if admitted), coinsurance 20%	\$100 copay (waived if admitted), coinsurance 20%	\$100 copay (waived if admitted), coinsurance 20%
Annual Routine Ob/Gyn Exam (Annual Pap/Mammogram)	Covered (Ded. Waived)	50%	Covered (Ded. Waived)	50%	Covered (Ded. Waived)	50%
Maternity Obstetrician Visits	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Preventive Health (Annual Physical) (\$200 per calendar year*)	\$20 copay (Ded. Waived)	50%	\$25 copay (Ded. Waived)	50%	\$30 copay (Ded. Waived)	50%
Lab/X-Ray	20%	50%	20%	50%	20%	50%
Skilled Nursing (in lieu of hospital) (30 days per calendar year*)	20%	50%	20%	50%	20%	50%
Physical/Occupational Therapy (24 visits per calendar year*)	20% (Aetna will pay a maximum of \$25 per visit)	50% (Aetna will pay a maximum of \$25 per visit)	20% (Aetna will pay a maximum of \$25 per visit)	50% (Aetna will pay a maximum of \$25 per visit)	20% (Aetna will pay a maximum of \$25 per visit)	50% (Aetna will pay a maximum of \$25 per visit)
Home Health Care (30 visits per calendar year*)	20%	50%	20%	50%	20%	50%
Durable Medical Equipment (\$2,000 per calendar year*)	20%	50%	20%	50%	20%	50%
PHARMACY						
Pharmacy Deductible	\$250 (does not apply to generic)	\$250 (does not apply to generic)	\$250 (does not apply to generic)	\$250 (does not apply to generic)	\$500 (does not apply to generic)	\$500 (does not apply to generic)
Generic (Oral Contraceptives Included)	\$15 copay	\$15 copay plus 50%	\$15 copay	\$15 copay plus 50%	\$15 copay	\$15 copay plus 50%
Preferred Brand/Non-Preferred Brand (Oral Contraceptives Included)	\$25/\$40 copay after deductible	\$25/\$40 copay plus 50% after deductible	\$25/\$40 copay after deductible	\$25/\$40 copay plus 50% after deductible	\$25/\$40 copay after deductible	\$25/\$40 copay plus 50% after deductible
Calendar Year Maximum per Individual*	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000

* Maximum applies to combined in and out of network benefits

For a full list of benefit coverage and exclusions refer to the plan documents.

MEMBER BENEFITS	OHIO PPO 5000		HIGH DEDUCTIBLE PPO 1 (HSA COMPATIBLE*)		HIGH DEDUCTIBLE PPO 2 (HSA COMPATIBLE*)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Individual/Family	\$5,000/\$10,000	\$10,000/\$20,000	\$2,750/\$5,500	\$5,500/\$11,000	\$5,000/\$10,000	\$10,000/\$20,000
Coinsurance	20%	50%	20%	50%	0%	0%
Out-of-Pocket Maximum (includes deductible) Individual/Family	\$7,500/\$15,000	\$12,500/\$25,000	\$5,000/\$10,000	\$10,000/\$20,000	\$5,000/\$10,000	\$10,000/\$20,000
Lifetime Maximum*	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrician or Internist)	\$40 copay (Ded. Waived)	50%	20%	50%	0%	0%
Specialist Visit	\$50 copay (Ded. Waived)	50%	20%	50%	0%	0%
Hospital Admission	20%	50%	20%	50%	0%	0%
Outpatient Surgery	20%	50%	20%	50%	0%	0%
Emergency Room	\$100 copay (waived if admitted), coinsurance 20%	\$100 copay (waived if admitted), coinsurance 20%	\$100 copay (waived if admitted), coinsurance 20%	\$100 copay (waived if admitted), coinsurance 20%	0%	0%
Annual Routine Ob/Gyn Exam (Annual Pap/Mammogram)	Covered (Ded. Waived)	50%	Covered (Ded. Waived)	50%	Covered (Ded. Waived)	0%
Maternity Obstetrician Visits	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Preventive Health (Annual Physical) (\$200 per calendar year*)	\$40 copay (Ded. Waived)	50%	\$20 copay (Ded. Waived)	50%	\$25 copay (Ded. Waived)	0%
Lab/X-Ray	20%	50%	20%	50%	0%	0%
Skilled Nursing (in lieu of hospital) (30 days per calendar year*)	20%	50%	20%	50%	0%	0%
Physical/Occupational Therapy (24 visits per calendar year*)	20% (Aetna will pay a maximum of \$25 per visit)	50% (Aetna will pay a maximum of \$25 per visit)	20% (Aetna will pay a maximum of \$25 per visit)	50% (Aetna will pay a maximum of \$25 per visit)	0% (Aetna will pay a maximum of \$25 per visit)	0% (Aetna will pay a maximum of \$25 per visit)
Home Health Care (30 visits per calendar year*)	20%	50%	20%	50%	0%	0%
Durable Medical Equipment (\$2,000 per calendar year*)	20%	50%	20%	50%	0%	0%
PHARMACY						
Pharmacy Deductible	\$500 (does not apply to generic)	\$500 (does not apply to generic)	Integrated Medical/ RX deductible	Integrated Medical/ RX deductible	Integrated Medical/ RX deductible	Integrated Medical/ RX deductible
Generic (Oral Contraceptives Included)	\$15 copay	\$15 copay plus 50%	\$15 copay	\$15 copay plus 50%	0%	0%
Preferred Brand/Non-Preferred Brand (Oral Contraceptives Included)	\$25/\$40 copay after deductible deductible	\$25/\$40 copay plus 50% after deductible	\$25/\$40 copay	\$25/\$40 copay plus 50%	0%	0%
Calendar Year Maximum per Individual*	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000

* Maximum applies to combined in and out of network benefits

* Based upon Treasury guidance available as of the print date.

For a full list of benefit coverage and exclusions refer to the plan documents.