MEDICAL PPO PROVIDER PLANS

Plans	Aultcare		Medical Mutual of Ohio		SummaCare Health	
	In Network	Non Network	In Network	Non Network	In Network	Non Network
Calendar Year Deductible						
Individual	$300	$600	$300	$600	$300	$600
Family	$600	$1,200	$600	$1,200	$600	$1,200
Co-Insurance	90%	75%	90%	75%	90%	75%
Out-Of-Pocket Maximum						
Individual	$1,000	$2,000	$1,000	$2,000	$1,000	$2,000
Family	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000
Preventative Care Services						
Preventative Services in accordance with State and Federal law [1]	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance
Routine Physical Exam (age 21 and older X 1 per year) [2]	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance
Well Child Care Services-birth to age 21-31 visits life time max	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance
Well Child Care Immunizations birth to age 21	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance
Well Child Clinical Laboratory Tests-birth to age 21	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance
Routine X-Rays birth to age 21	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance
Routine Mammogram (One per benefit period)	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance
Routine Pap Test (One per benefit period)	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance
Routine Endoscopic Services (age 50 and over)	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance
Routine Chest X-Ray, Complete Blood Count, Comprehensive Metabolic Panel, EKG, Urinalysis (one each per benefit period)	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance
Routine PSA Test (one per benefit period)	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance	Covered 100%	Deductible + 75% Co-Insurance

Physician/Office Services						
Office Visit (Illness/Injury) [2]	$25 copay, 90% co-insurance	Deductible + 75% Co-Insurance	$25 copay, 90% co-insurance	Deductible + 75% Co-Insurance	$25 copay, 90% co-insurance	Deductible + 75% Co-Insurance
Specialist Office Visit [2]	$25 copay, 90% co-insurance	Deductible + 75% Co-Insurance	$25 copay, 90% co-insurance	Deductible + 75% Co-Insurance	$25 copay, 90% co-insurance	Deductible + 75% Co-Insurance
Urgent Care Office Visit [2]	$50 copay, 90% co-insurance	Deductible + 75% Co-Insurance	$50 copay, 90% co-insurance	Deductible + 75% Co-Insurance	$50 copay, 90% co-insurance	Deductible + 75% Co-Insurance
Immunizations	100% after deductible	Deductible + 75% Co-Insurance	100% after deductible	Deductible + 75% Co-Insurance	100% after deductible	Deductible + 75% Co-Insurance
Hospital Services						
In-Patient Services	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance	Deductible + 90% Co-Insurance	Deductible + 75% Co-Insurance	Deductible + 90% Co-Insurance	Deductible + 75% Co-Insurance
Out-Patient Services	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance	Deductible + 90% Co-Insurance	Deductible + 75% Co-Insurance	Deductible + 90% Co-Insurance	Deductible + 75% Co-Insurance
Physical Therapy & Occupational Therapy-Facility and Professional--60 visit total per benefit period	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance
Chiropractic Therapy-Professional Only 12 visits per benefit period	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance
Speech Therapy-Facility and Professiona-20 visits total per benefit period	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance
Skilled Nursing Facility- 180 day max per benefit period	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance
Hospice Services	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance
Durable Medical Equipment	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance
Home Healthcare-180 visit max per benefit period	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance	Deductible + 90% co-Insurance	Deductible + 75% Co-Insurance
Emergency Room [3]	$50 copay+90% co-insurance	Deductible + 75% Co-Insurance	$50 copay+90% co-insurance	Deductible + 75% Co-Insurance	$50 copay+90% co-insurance	Deductible + 75% Co-Insurance

Mental Health And Substance Abuse-Federal Mental Health Parity			
Inpatient Mental Health and Substance Abuse Services	Benefits Paid on Corresponding Medical Benefits	Benefits Paid on Corresponding Medical Benefits	Benefits Paid on Corresponding Medical Benefits
Out Patient Mental Health and Substance Abuse Services	Benefits Paid on Corresponding Medical Benefits	Benefits Paid on Corresponding Medical Benefits	Benefits Paid on Corresponding Medical Benefits
Prescription Benefits *(Express Scripts)*			
Retail Program-30 Day Supply	$10 Generic/$30 Brand Name	$10 Generic/$30 Brand Name	$10 Generic/$30 Brand Name
Mail Order Program-90 Day Supply	$10 Generic/$30 Brand Name	$10 Generic/$30 Brand Name	$10 Generic/$30 Brand Name
Out Of Pocket Maximum	$5,000 out-of-pocket max	$5,000 out-of-pocket max	$5,000 out-of-pocket max
Monthly Employee Premiums *(**Discounts available for Wellness Program Participants)*			
Individual	$50/month	$50/month	$50/month
Family	$100/month	$100/month	$100/month

Deductible expenses incurred for services by a non-network provider will also apply to the network deductible out-of-pocket limits. Deductible expenses incurred for services by a network provider will also apply to the non-network deductible and coinsurance out-to-pocket limits.

1 Preventative services include evidence-based services that have a rating of "A" or "B" in the United States Preventative Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.

2 The Office Visit copay applies to the cost of the office visit only.

3 Copay waived if admitted for inpatient treatment. The copay applies to room charges only. All other covered charges are not subject to deductible

This guide provides information regarding employee benefits. More detailed information is available from plan documents and contracts. The information presented here is not intended as a contract or promise of benefits of any kind, and therefore, should not be interpreted as such. Not all of the plan provisions, limitation and exclusions are included in this publication. In the event of any conflict between the information contained in this publication and the plan provisions, the plan documents and contracts will govern.