HEALTH-e OHIO™

Plan Comparisons

All plan benefits shown are as a percentage of Eligible Charge

	EPO250		*EPO750*	
Description of Benefits	**Skyway Health**	**Non-Par Providers**	**Skyway Health**	**Non-Par Providers**
Annual Deductible (Per Person / Per Family)	$250 / $500	Not Applicable	$750 / $2,250	Not Applicable
Maximum Out-of-Pocket (Per Person / Per Family)	$750 / $1,500	Not Applicable	$1,750 / $5,250	Not Applicable
Amounts in Excess of Negotiated Rates	Amounts Listed*	Not Applicable	Amounts Listed*	Not Applicable
Primary Care Physician Office Visits (Per Visit)	$5 Copay	Not Covered	$15 Copay	Not Covered
Specialist Physician Office Visits (Per Visit)	$10 Copay	Not Covered	$30 Copay	Not Covered
Other Physician Services (In-Office)	10% Coinsurance**	Not Covered	10% Coinsurance**	Not Covered
Other Physician Services (In-Facility)	10% Coinsurance**	Not Covered	10% Coinsurance**	Not Covered
Urgent Care Visits (Per Visit)	$35 Copay	Not Covered	$45 Copay	Not Covered
Telemedicine Visits (Unlimited Visits)	$0 Copay	Not Covered	$0 Copay	Not Covered
Preventive Care (Adult, Women, Children)	$0 Copay	Not Covered	$0 Copay	Not Covered
Emergency Room	$250 Copay at Skyway Health	$250 Copay** ***	$250 Copay at Skyway Health	$250 Copay** ***
Inpatient Room & Care	10% Coinsurance**	Not Covered	10% Coinsurance**	Not Covered
Inpatient Room & Care (Services not available at MetroHealth Facilities)	Not Available	10% Coinsurance** ***	Not Available	10% Coinsurance** ***
Outpatient/Ambulatory Surgery Services (Hospital & Non-Hospital Setting)	10% Coinsurance**	Not Covered	10% Coinsurance**	Not Covered
Laboratory Services (CT/MRI/MRA/PET Scan) (Services available at MetroHealth Facilities)	10% Coinsurance**	Not Covered	10% Coinsurance**	Not Covered
Laboratory Services (CT/MRI/MRA/PET Scan) (Services not available at MetroHealth Facilities)	Not Available	10% Coinsurance**	Not Available	10% Coinsurance**
Ground Ambulance (Non-Emergent)	Not Available	10% Coinsurance**	Not Available	10% Coinsurance**
Air Ambulance	Not Available	40% Coinsurance**	Not Available	40% Coinsurance**
Chemotherapy	10% Coinsurance**	Not Covered	10% Coinsurance**	Not Covered
Acupuncture	$35 Copay ***		$35 Copay ***	
Chiropractic Care	$35 Copay ***		$35 Copay ***	
Naturopathy	$35 Copay ***		$35 Copay ***	
Massage Therapy	$35 Copay ***		$35 Copay ***	
Pharmacy Benefits	**MetroHealth**	**Drug Mart**	**MetroHealth**	**Drug Mart**
Annual Deductible	None		None	
Preventive Prescription Drugs (Generic Only) (Pharmacy Retail - Up to a 31 Day Supply)	$0 Copay		$0 Copay	
Retail Prescription Drugs (Up to a 31 Day Supply)	$5 / $10 / $25	$20 / $40 / $75	$5 / $10 / $25	$20 / $40 / $75
Retail Prescription Drugs (90 Day Supply)	$15 / $30 / $75	$60 / $120/ $225	$15 / $30 / $75	$60 / $120/ $225
Specialty Drugs	20% Coinsurance		20% Coinsurance	

Pharmacy Tier 2: Welldyne Network Pharmacies

* *For Preferred Providers, the Member is responsible only for the Deductible, Coinsurance and/or Copayment amounts indicated*

** *Corresponding Deductible Applies (unless otherwise indicated at the service level)*

*** *Copay and/or Coinsurance plus amounts that exceed Reasonable & Allowed Charge*

HEALTH-e OHIO™

Plan Comparisons

All plan benefits shown are as a percentage of Eligible Charge

	*PPO*250-2500		*PPO*250-5000	
Description of Benefits	**Tier 1**	**Tier 2**	**Tier 1**	**Tier 2**
Physician & Hospital Network	**Skyway Health**	**PHCS + RBP**	**Skyway Health**	**PHCS + RBP**
Annual Deductible (Per Person / Per Family)	$250 / $750	$2,500 / $7,500	$250 / $750	$5,000 / $15,000
Maximum Out-of-Pocket (Per Person / Per Family)	$750 / $2,250	$6,500 / $19,500	$750 / $2,250	$5,000 / $15,000
Amounts in Excess of Negotiated Rates	Deductible, Coinsurance &/or Copayment Indicated Below*		Deductible, Coinsurance &/or Copayment Indicated Below*	
Primary Care Physician Office Visits (Per Visit)	$5 Copay	$45 Copay	$5 Copay	0% Coinsurance**
Specialist Physician Office Visits (Per Visit)	$10 Copay	$75 Copay	$10 Copay	0% Coinsurance**
Other Physician Services (In-Office)	10% Coinsurance**	30% Coinsurance**	10% Coinsurance**	0% Coinsurance**
Other Physician Services (In-Facility)	10% Coinsurance**	30% Coinsurance**	10% Coinsurance**	0% Coinsurance**
Urgent Care Visits (Per Visit)	$35 Copay	$60 Copay	$35 Copay	0% Coinsurance**
Telemedicine Visits (Unlimited Visits)	$0 Copay	Not Covered	$0 Copay	Not Covered
Preventive Care (Adult, Women, Children)	$0 Copay	0% Coinsurance**	$0 Copay	0% Coinsurance**
Emergency Room	$250 Copay at Skyway Health	0% Coinsurance**	$250 Copay at Skyway Health	$250 Copay*
Inpatient Room & Care	10% Coinsurance**	30% Coinsurance**	10% Coinsurance**	0% Coinsurance**
Outpatient/Ambulatory Surgery Services (Non-Hospital Setting)	10% Coinsurance**	30% Coinsurance**	10% Coinsurance**	0% Coinsurance**
Outpatient/Ambulatory Surgery Services (Hospital Setting)	10% Coinsurance**	30% Coinsurance** ***	10% Coinsurance**	0% Coinsurance** ***
Laboratory Services (Non-Hospital Based)	10% Coinsurance**	30% Coinsurance**	10% Coinsurance**	0% Coinsurance**
Laboratory Services (Hospital Based)	10% Coinsurance**	50% Coinsurance**	10% Coinsurance**	50% Coinsurance**
CT/MRI/MRA/PET Scan (Non-Hospital Based)	10% Coinsurance**	30% Coinsurance**	10% Coinsurance**	0% Coinsurance**
CT/MRI/MRA/PET Scan (Hospital Based)	10% Coinsurance**	50% Coinsurance**	10% Coinsurance**	50% Coinsurance**
Ground Ambulance	10% Coinsurance**		10% Coinsurance**	
Air Ambulance	40% Coinsurance**		40% Coinsurance**	
Chemotherapy	10% Coinsurance**	30% Coinsurance**	10% Coinsurance**	0% Coinsurance**
Acupuncture	$35 Copay ***		$35 Copay ***	
Chiropractic Care	$35 Copay ***		$35 Copay ***	
Naturopathy	$35 Copay ***		$35 Copay ***	
Massage Therapy	$35 Copay ***		$35 Copay ***	
Pharmacy Benefits	**Tier 1A**	**Tier 1B**	**Tier 1A**	**Tier 1B**
Pharmacy Network	**MetroHealth**	**Drug Mart**	**MetroHealth**	**Drug Mart**
Annual Deductible	None		None	
Preventive Prescription Drugs (Generic Only) (Pharmacy Retail - Up to a 31 Day Supply)	$0 Copay		$0 Copay	
Retail Prescription Drugs (Up to a 31 Day Supply)	$5 / $10 / $25	$20 / $40 / $75	$5 / $10 / $25	$20 / $40 / $75
Retail Prescription Drugs (90 Day Supply)	$15 / $30 / $75	$60 / $120/ $225	$15 / $30 / $75	$60 / $120/ $225
Specialty Drugs	20% Coinsurance		20% Coinsurance	

Medical Tier 3: Non-Participating Providers
Each plan contains a 3rd tier option for non-participating providers. Separate deductibles and benefits apply.
For additional benefit information, please see the full Description of Benefits.
Pharmacy Tier 2: Welldyne Network Pharmacies

* *For Preferred Providers, the Member is responsible only for the Deductible, Coinsurance and/or Copayment amounts indicated*
** *Corresponding Deductible Applies (unless otherwise indicated at the service level)*
*** *Copay and/or Coinsurance plus amounts that exceed Reasonable & Allowed Charge*

HEALTH-e OHIO™

Plan Comparisons

All plan benefits shown are as a percentage of Eligible Charge

	*PPO*500-5000		*PPO*750-6500	
Description of Benefits	**Tier 1**	**Tier 2**	**Tier 1**	**Tier 2**
Physician & Hospital Network	**Skyway Health**	**PHCS + RBP**	**Skyway Health**	**PHCS + RBP**
Annual Deductible (Per Person / Per Family)	$500 / $1,500	$5,000 / $15,000	$750 / $2,250	$6,500 / 19,500
Maximum Out-of-Pocket (Per Person / Per Family)	$1,500 / $4,500	$9,000 / $27,000	$1,750 / $5,250	$6,500 / $19,500
Amounts in Excess of Negotiated Rates	Deductible, Coinsurance &/or Copayment Indicated Below*		Deductible, Coinsurance &/or Copayment Indicated Below*	
Primary Care Physician Office Visits (Per Visit)	$15 Copay	$45 Copay	$15 Copay	0% Coinsurance**
Specialist Physician Office Visits (Per Visit)	$30 Copay	$75 Copay	$30 Copay	0% Coinsurance**
Other Physician Services (In-Office)	10% Coinsurance**	30% Coinsurance**	10% Coinsurance**	0% Coinsurance**
Other Physician Services (In-Facility)	10% Coinsurance**	30% Coinsurance**	10% Coinsurance**	0% Coinsurance**
Urgent Care Visits (Per Visit)	$45 Copay	$60 Copay	$45 Copay	0% Coinsurance**
Telemedicine Visits (Unlimited Visits)	$0 Copay	Not Covered	$0 Copay	Not Covered
Preventive Care (Adult, Women, Children)	$0 Copay	0% Coinsurance**	$0 Copay	0% Coinsurance**
Emergency Room	$250 Copay	$250 Copay ** ***	$250 Copay	$250 Copay** ***
Inpatient Room & Care	10% Coinsurance**	30% Coinsurance** ***	10% Coinsurance**	0% Coinsurance** ***
Outpatient/Ambulatory Surgery Services (Non-Hospital Setting)	10% Coinsurance**	30% Coinsurance**	10% Coinsurance**	10% Coinsurance**
Outpatient/Ambulatory Surgery Services (Hospital Setting)	10% Coinsurance**	30% Coinsurance** ***	10% Coinsurance**	50% Coinsurance** ***
Laboratory Services (Non-Hospital Based)	10% Coinsurance**	30% Coinsurance**	10% Coinsurance**	0% Coinsurance**
Laboratory Services (Hospital Based)	10% Coinsurance**	50% Coinsurance**	10% Coinsurance**	50% Coinsurance**
CT/MRI/MRA/PET Scan (Non-Hospital Based)	10% Coinsurance**	30% Coinsurance**	10% Coinsurance**	0% Coinsurance**
CT/MRI/MRA/PET Scan (Hospital Based)	10% Coinsurance**	50% Coinsurance** ***	10% Coinsurance**	50% Coinsurance**
Ground Ambulance	10% Coinsurance** ***		10% Coinsurance**	
Air Ambulance	40% Coinsurance** ***		40% Coinsurance**	
Chemotherapy	10% Coinsurance**	30% Coinsurance**	10% Coinsurance**	0% Coinsurance**
Acupuncture	$35 Copay ***		$35 Copay ***	
Chiropractic Care	$35 Copay ***		$35 Copay ***	
Naturopathy	$35 Copay ***		$35 Copay ***	
Massage Therapy	$35 Copay ***		$35 Copay ***	
Pharmacy Benefits	**Tier 1A**	**Tier 1B**	**Tier 1A**	**Tier 1B**
Pharmacy Network	MetroHealth	Drug Mart	MetroHealth	Drug Mart
Annual Deductible	None		None	
Preventive Prescription Drugs (Generic Only) (Pharmacy Retail - Up to a 31 Day Supply)	$0 Copay		$0 Copay	
Retail Prescription Drugs (Up to a 31 Day Supply)	$5 / $10 / $25	$20 / $40 / $75	$5 / $10 / $25	$20 / $40 / $75
Retail Prescription Drugs (90 Day Supply)	$15 / $30 / $75	$60 / $120/ $225	$15 / $30 / $75	$60 / $120/ $225
Specialty Drugs	20% Coinsurance		20% Coinsurance	

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