Youngstown City Schools
Benefit Plan Comparison (includes Health Care Reform) with Proposed PPO Plan - Option 1

Network Type	**Classified PPO Plan** *Hospital & Physcian Network*		**Proposed PPO Plan - OPTION 1** *Hospital & Physcian Network*		**Certified PPO 1 Plan** *Hospital & Physcian Network*		**Certified Modified Traditional Plan** *Hospital Only Network*	
Benefits	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network Facility / AND Professional Provider**	**Non-Network Facility Only**
Benefit Period	January 1st through December 31st		January 1st through December 31st		January 1st through December 31st		January 1st through December 31st	
Dependent Age Limit	Age 26; Removal upon End of Month		Age 26; Removal upon End of Month		Age 26; Removal upon End of Month		Age 26; Removal upon End of Month	
Over Age Dependent Limit	Age 28; Removal upon End of Month (at Cardholder's Expense)		Age 28; Removal upon End of Month (at Cardholder's Expense)		Age 28; Removal upon End of Month (at Cardholder's Expense)		Age 28; Removal upon End of Month (at Cardholder's Expense)	
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
Human Organ Transplant Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
Benefit Period Deductible - Single/Family [1]	None	$50 Single/$100 Family [2]	$50 Single/$100 Family		Base: None; SMM $50 Single/$100 Family		$50 Single / $100 Family	
Coinsurance	90%	70%	90%	70%	Base: 100%; SMM: 90%	Base: 70%; SMM: 90%	90%	80%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	$225 Single/$450 Family [3]	No Limit	$225 Single/$450 Family	No Limit	Base: None; SMM: $225 Per Person	Base: $2,000 Per Person;	$225 Per Covered Person [4]	$2,000 Per Covered Person [4]
Physician/Office Services								
Office Visit (Illness/Injury)	90%, no deductible	70% after deductible	$10 copay; then 90%	$10 copay; then 70%	SMM Only: 90% after deductible		90% after deductible	
Urgent Care Facility Services								
Accident or Initial Injury care rendered within 2 days of Injury	100% no deductible		$25 copay, then 100% for all urgent care	$25 copay, then 70% for all urgent care	SMM Only 90% after deductible		90% after deductible	
Accident or Initial Injury care rendered after 2 days of Injury	90%, no deductible				SMM Only 90% after deductible		90% after deductible	
Medical Emergency	$45 copayment; then 100%				SMM Only 90% after deductible		90% after deductible	
Allergy Testing	90%, no deductible	70% after deductible	90% after deductible	70% after deductible	Base: 100%; SMM: 90% after deductible	Base: 70%;	90% after deductible	80% after deductible
Allergy Treatments	90%, no deductible	70% after deductible	90% after deductible	70% after deductible	SMM Only: 90% after deductible		90% after deductible	
ALL Immunizations	100%, no deductible	70%, no deductible	90%, no deductible	70%, no deductible	Not Covered		Not Covered	
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	Included Above		Included Above		SMM Only: 90% after deductible		90% after deductible	
Voluntary Second Surgical Opinion	100%, no deductible	70%, no deductible	$10 copay, then 90%	$10 copay; then 70%	Base: 100% SMM: 100%, no deductible	Base: 70%	90% after deductible	
Preventive Services								
Routine Physical Exam	Not Covered		$10 copay, then 100%	$10 copay; then 70%	Not Covered		Not Covered	
Routine OB/GYN Exam (One per benefit period)	100%, no deductible	70%, no deductible	$10 copay, then 100%	$10 copay; then 70%	SMM Only: 90% after deductible		90% after deductible	
Well Child Care Services including Exam and Immunizations	100%, no deductible	70%, no deductible	$10 copay, then 100%; 90% no deductible all other services	$10 copay; then 70%; 70% no deductible all other services	SMM Only: 90% after deductible		90% after deductible	
Well Child Care Laboratory Tests - Birth to Age 9	Not Covered		90% no deductible	70% no deductible	SMM Only: 90% after deductible		90% after deductible	80% after deductible
Routine EKG, Chest X-Ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period)	Not Covered		90% no deductible	70% no deductible	Base: 100%	Base: 70%	Not Covered	
Routine Mammogram (One per benefit period)	100%, no deductible Ages 35+	70%, no deductible	90% no deductible	70% no deductible	Base: 100%	Base: 70%	90% after deductible	80% after deductible
Routine PAP (One per benefit period)	100%, no deductible	70%, no deductible	90% no deductible	70% no deductible	Base: 100%	Base: 70%	90% after deductible	80% after deductible
Routine PSA Test (One per benefit period)	100%, no deductible	70%, no deductible	90% no deductible	70% no deductible	Base: 100%	Base: 70%	90% after deductible	80% after deductible
Routine Tuberculosis Tests	Not Covered		90% no deductible	70% no deductible	SMM Only: 90% after deductible		90% after deductible	80% after deductible
Routine Colorectal or Bone Density Screening	100%, no deductible	70%, no deductible	90% no deductible	70% no deductible	Not Covered		Not Covered	
Routine Hearing Test & Evaluation	Not Covered		90% no deductible	70% no deductible	Base: 100%	Base: 70%	90% after deductible	80% after deductible
Outpatient Services								
Surgical Services	100%, no deductible	70%, no deductible	90% after deductible	70% after deductible	Base: 100% SMM Only: 90% after deductible	Base: 70%	90% after deductible	80% after deductible
Diagnostic Services (X-rays, Lab & Medical tests)	100%, no deductible	70%, no deductible	90% after deductible	70% after deductible	Base: 100% SMM Only: 90% after deductible	Base: 70%	90% after deductible	80% after deductible
Physical / Chiropractic / Occupational Therapy (Facility and Professional) per benefit period	Physical & Occupational 100%, no deductible Chiro 90%, no deductible *Unlimited Visits*	70%, no deductible 80%, no deductible *Unlimited Visits*	90% after deductible *40 visits Physical & Occupational Therapy 12 visits Chiropractic*	70% after deductible	SMM Only: 90% after deductible *26 visits combined/cy, then subject to Medical Review*		90% after deductible *26 visits combined/cy, then subject to Medical Review*	80% after deductible
Speech Therapy - Facility and Professional	100%, no deductible *Unlimited Visits*	70%, no deductible *Unlimited Visits*	90% after deductible *20 visits for Speech Therapy*	70% after deductible	SMM Only: 90% after deductible *10 visits/cy, then subject to Medical Review*		90% after deductible *10 visits/cy, then subject to Medical Review*	80% after deductible

Network Type	**Classified PPO Plan** *Hospital & Physcian Network*		**Proposed PPO Plan - OPTION 1** *Hospital & Physcian Network*		**Certified PPO 1 Plan** *Hospital & Physcian Network*		**Certified Modified Traditional Plan** *Hospital Only Network*	
Benefits	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network Facility / AND Professional Provider**	**Non-Network Facility Only**
Cardiac Rehabilitation	100%, no deductible	70%, no deductible	90% after deductible	70% after deductible	SMM Only: 90% after deductible		90% after deductible	80% after deductible
Professional Medical Services	100%, no deductible	70%, no deductible	[1]	[1]	Base: 100% SMM Only: 90% after deductible	Base: 70%	90% after deductible	
Emergency use of an Emergency Room			$50 copay, then 100% for accident or med emergency Copay waived if admitted	$50 copay, then 100% accident or med emergency Copay waived if admitted				
Accident or Initial Injury care rendered within 2 days of Injury	100% no deductible				Base: 100%		90% after deductible	
Accident or Initial Injury care rendered after 2 days of Injury	90%, no deductible				SMM Only: 90% after deductible		90% after deductible	
Medical Emergency	$45 copayment; then 100%. Copay Waived if Admitted				Base: 100%		90% after deductible	
Non-Emergency Use of ER	$45 copayment; then 100%. Copay Waived if Admitted		$50 copay, then 90%	$50 copay, then 70%	SMM Only: 90% after deductible		90% after deductible	
Supplemental Accident Care (Limited to the first $300 of services received within 90 days after an accident)	Not Covered		First $300 covered at 100%, then 90% after deductible	First $300 covered at 100%, then 90% after deductible	Base: First $300 at 100%, then SMM: 90% after deductible		First $300 covered at 100%, then 90% after deductible	80% after deductible
Inpatient Facility								
Semi-Private Room and Board	1st 365 days, 100% no deductible. After 365 days, 90%, no deductible	70%, no deductible	90% after deductible	70% after deductible	Base: 100% SMM: 90% after deductible *365 day per in-hospital benefit period*	Base: 70%	90% after deductible	80% after deductible
Inpatient Consultations	100%, no deductible	70%, no deductible	90% after deductible	70% after deductible	Base: 100% SMM: 90% after deductible *365 day per in-hospital benefit period*	Base: 70%	90% after deductible	
Maternity	100%, no deductible	70%, no deductible	90% after deductible	70% after deductible	Base: 100% SMM: 90% after deductible	Base: 70%	90% after deductible	80% after deductible
Inpatient Newborn Care	100%, no deductible	70%, no deductible	90% after deductible	70% after deductible	Base: 100% SMM: 90% after deductible	Base: 70%	90% after deductible	
Additional Services								
Ambulance (includes air if medically necessary)	$40 copayment; then 100%		90% after deductible	70% after deductible	Base: 100%	Base: 70%	90% after deductible	
Durable Medical Equipment	90%, no deductible	70% after deductible	90% after deductible	70% after deductible	SMM Only: 90% after deductible		90% after deductible	80% after deductible
Other Medical Supplies	100%, no deductible	70%, no deductible	90% after deductible	70% after deductible	SMM Only: 90% after deductible		90% after deductible	80% after deductible
Home Healthcare	100% no deductible		90% after deductible	70% after deductible	SMM Only: 90% after deductible		90% after deductible	80% after deductible
Hospice	100% no deductible		90% after deductible	70% after deductible	SMM Only: 90% after deductible		90% after deductible	80% after deductible
Human Organ Transplants	100%, no deductible	70%, no deductible	90% after deductible	70% after deductible	Base: 100% SMM Only: 90% after deductible	Base: 70%	90% after deductible	80% after deductible
Prescription Drug Deductibles & Injectble Insulin	90% after deductible		Not Covered		SMM Only: 90% after deductible		90% after deductible	
Private Duty Nursing	90%, no deductible	70% after deductible	90% after deductible	70% after deductible	SMM Only: 90% after deductible		90% after deductible	
Skilled Nursing Facility	1st 365 days, 100% no deductible. After 365 days, 90%, no deductible	70%, no deductible	90% after deductible	70% after deductible	SMM Only: 90% after deductible		90% after deductible	80% after deductible
Dental/Oral Surgery & Accident	100%, no deductible	70%, no deductible	90% after deductible	70% after deductible	SMM Only: 90% after deductible		90% after deductible	80% after deductible
TMJ Services	90%, no deductible	70% after deductible	90% after deductible	70% after deductible	Base: 100% SMM: 90% after deductible	Base: 70%	90% after deductible	80% after deductible
Mental Health and Substance Abuse								
Inpatient Mental Health and Substance Abuse Services	Covered in Full; No Deductible	70% Coinsurance; No Deductible	90% after deductible	70% after deductible	Base: 100% SMM Only: 90% after deductible	Base: 70%	90% after deductible	80% after deductible
Outpatient Mental Health and Substance Abuse Services	Benefits are based on corresponding medical benefits		90% after deductible or $10 copay then 90% if office visit.	70% after deductible or $10 copay then 70% if office visit.	Base: 100% SMM Only: 90% after deductible Outpt Drug Abuse only covered under SMM.	Base: 70%	90% after deductible	80% after deductible

[1] Three (3) month deductible carryover applies.

[2] The Non-Network deductible applies ONLY to Durable Medical Equipment, Office Visits, Private Duty Nursing and TMJ Services. **(NOT APPLICABLE TO PROPOSED PLAN)**

[3] The OOP limit applies ONLY to Ambulance, Emergency (accidents and medical emergencies), Urgent Care, Durable Medical Equipment, Office Visits, Private Duty Nursing, Skilled Nursing, Spinal Manipulations, Inpatient Facility Services and TMJ Services. It includes all flat dollar copayments incurred in a benefit period. **(NOT APPLICABLE TO PROPOSED PLAN)**

[4] Network and Non-Network Deductibles accumulate towards each other. However, Network and Non-Network OOP limits are separate and do not accumulate towards each other.

Youngstown City Schools
Benefit Plan Comparison (includes Health Care Reform) with Proposed PPO Plan - Option 2

Network Type	Classified PPO Plan *Hospital & Physcian Network*		Proposed PPO Plan - OPTION 2 *Hospital & Physcian Network*		Certified PPO 1 Plan *Hospital & Physcian Network*		Certified Modified Traditional Plan *Hospital Only Network*	
Benefits	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network Facility / AND Professional Provider**	**Non-Network Facility Only**
Benefit Period	January 1st through December 31st		January 1st through December 31st		January 1st through December 31st		January 1st through December 31st	
Dependent Age Limit	Age 26; Removal upon End of Month		Age 26; Removal upon End of Month		Age 26; Removal upon End of Month		Age 26; Removal upon End of Month	
Over Age Dependent Limit	Age 28; Removal upon End of Month (at Cardholder's Expense)		Age 28; Removal upon End of Month (at Cardholder's Expense)		Age 28; Removal upon End of Month (at Cardholder's Expense)		Age 28; Removal upon End of Month (at Cardholder's Expense)	
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
Human Organ Transplant Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
Benefit Period Deductible - Single/Family [1]	None	$50 Single/$100 Family [2]	$50 Single/$100 Family		Base: None; SMM $50 Single/$100 Family		$50 Single / $100 Family	
Coinsurance	90%	70%	90%	70%	Base: 100%; SMM: 90%	Base: 70%; SMM: 90%	90%	80%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	$225 Single/$450 Family [3]	No Limit	$225 Single/$450 Family	No Limit	Base: None; SMM: $225 Per Person	Base: $2,000 Per Person;	$225 Per Covered Person [4]	$2,000 Per Covered Person [5]
Physician/Office Services								
Office Visit (Illness/Injury)	90%, no deductible	70% after deductible	90% after deductible	70% after deductible	SMM Only: 90% after deductible		90% after deductible	
Urgent Care Facility Services	100% no deductible		$25 copay, then 100% for all urgent care	$25 copay, then 70% for all urgent care	SMM Only 90% after deductible		90% after deductible	
Accident or Initial Injury care rendered within 2 days of Injury	90%, no deductible				SMM Only 90% after deductible		90% after deductible	
Accident or Initial Injury care rendered after 2 days of Injury	$45 copayment; then 100%				SMM Only 90% after deductible		90% after deductible	
Medical Emergency								
Allergy Testing	90%, no deductible	70% after deductible	90% after deductible	70% after deductible	Base: 100%; SMM: 90% after deductible	Base: 70%;	90% after deductible	80% after deductible
Allergy Treatments	90%, no deductible	70% after deductible	90% after deductible	70% after deductible	SMM Only: 90% after deductible		90% after deductible	
ALL Immunizations	100%, no deductible	70%, no deductible	90%, no deductible	70%, no deductible	Not Covered		Not Covered	
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	Included Above		Included Above		SMM Only: 90% after deductible		90% after deductible	
Voluntary Second Surgical Opinion	100%, no deductible	70%, no deductible	90% after deductible	70% after deductible	Base: 100% SMM: 100%, no deductible	Base: 70%	90% after deductible	
Preventive Services								
Routine Physical Exam	Not Covered		90% no deductible	70% no deductible	Not Covered		Not Covered	
Routine OB/GYN Exam (One per benefit period)	100%, no deductible	70%, no deductible	90% no deductible	70% no deductible	SMM Only: 90% after deductible		90% after deductible	
Well Child Care Services including Exam and Immunizations	100%, no deductible	70%, no deductible	90% no deductible	70% no deductible	SMM Only: 90% after deductible		90% after deductible	
Well Child Care Laboratory Tests - Birth to Age 9	Not Covered		90% no deductible	70% no deductible	SMM Only: 90% after deductible		90% after deductible	80% after deductible
Routine EKG, Chest X-Ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period)	Not Covered		90% no deductible	70% no deductible	Base: 100%	Base: 70%	Not Covered	
Routine Mammogram (One per benefit period)	100%, no deductible Ages 35+	70%, no deductible	90% no deductible	70% no deductible	Base: 100%	Base: 70%	90% after deductible	80% after deductible
Routine PAP (One per benefit period)	100%, no deductible	70%, no deductible	90% no deductible	70% no deductible	Base: 100%	Base: 70%	90% after deductible	80% after deductible
Routine PSA Test (One per benefit period)	100%, no deductible	70%, no deductible	90% no deductible	70% no deductible	Base: 100%	Base: 70%	90% after deductible	80% after deductible
Routine Tuberculosis Tests	Not Covered		90% no deductible	70% no deductible	SMM Only: 90% after deductible		90% after deductible	80% after deductible
Routine Colorectal or Bone Density Screening	100%, no deductible	70%, no deductible	90% no deductible	70% no deductible	Not Covered		Not Covered	
Routine Hearing Test & Evaluation	Not Covered		90% no deductible	70% no deductible	Base: 100%	Base: 70%	90% after deductible	80% after deductible
Outpatient Services								
Surgical Services	100%, no deductible	70%, no deductible	90% after deductible	70% after deductible	Base: 100% SMM Only: 90% after deductible	Base: 70%	90% after deductible	80% after deductible
Diagnostic Services (X-rays, Lab & Medical tests)	100%, no deductible	70%, no deductible	90% after deductible	70% after deductible	Base: 100% SMM Only: 90% after deductible	Base: 70%	90% after deductible	80% after deductible
Physical / Chiropractic / Occupational Therapy (Facility and Professional) per benefit period	Physical & Occupational 100%, no deductible Chiro 90%, no deductible *Unlimited Visits*	70%, no deductible 80%, no deductible *Unlimited Visits*	90% after deductible *40 visits Physical & Occupational Therapy* *12 visits Chiropractic*	70% after deductible	SMM Only: 90% after deductible *26 visits combined'cy, then subject to Medical Review*		90% after deductible *26 visits combined'cy, then subject to Medical Review*	80% after deductible
Speech Therapy - Facility and Professional	100%, no deductible *Unlimited Visits*	70%, no deductible *Unlimited Visits*	90% after deductible *20 visits for Speech Therapy*	70% after deductible	SMM Only: 90% after deductible *10 visits'cy, then subject to Medical Review*		90% after deductible *10 visits'cy, then subject to Medical Review*	80% after deductible

Network Type	**Classified PPO Plan** *Hospital & Physcian Network*		**Proposed PPO Plan - OPTION 2** *Hospital & Physcian Network*		**Certified PPO 1 Plan** *Hospital & Physcian Network*		**Certified Modified Traditional Plan** *Hospital Only Network*	
Benefits	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network Facility / AND Professional Provider**	**Non-Network Facility Only**
Cardiac Rehabilitation	100%, no deductible	70%, no deductible	90% after deductible	70% after deductible	SMM Only: 90% after deductible		90% after deductible	80% after deductible
Professional Medical Services	100%, no deductible	70%, no deductible			Base: 100% SMM Only: 90% after deductible	Base: 70%	90% after deductible	
Emergency use of an Emergency Room								
Accident or Initial Injury care rendered within 2 days of Injury	100% no deductible		$50 copay, then 100% for accident or med emergency Copay waived if admitted	$50 copay, then 100% accident or med emergency Copay waived if admitted	Base: 100% SMM Only: 90% after deductible		90% after deductible	
Accident or Initial Injury care rendered after 2 days of Injury	90%, no deductible						90% after deductible	
Medical Emergency	$45 copayment; then 100%. Copay Waived if Admitted				Base: 100%		90% after deductible	
Non-Emergency Use of ER	$45 copayment; then 100%. Copay Waived if Admitted		$50 copay, then 90%	$50 copay, then 70%	SMM Only: 90% after deductible		90% after deductible	
Supplemental Accident Care (Limited to the first $300 of services received within 90 days after an accident)	Not Covered		First $300 covered at 100%, then 90% after deductible	80% after deductible	Base: First $300 at 100%, then SMM: 90% after deductible		First $300 covered at 100%, then 90% after deductible	80% after deductible
Inpatient Facility								
Semi-Private Room and Board	1st 365 days, 100% no deductible. After 365 days, 90%, no deductible	70%, no deductible	90% after deductible	70% after deductible	Base: 100% SMM: 90% after deductible *365 day per in-hospital benefit period*	Base: 70%	90% after deductible	80% after deductible
Inpatient Consultations	100%, no deductible	70%, no deductible	90% after deductible	70% after deductible	Base: 100% SMM: 90% after deductible *365 day per in-hospital benefit period*	Base: 70%	90% after deductible	
Maternity	100%, no deductible	70%, no deductible	90% after deductible	70% after deductible	Base: 100% SMM: 90% after deductible	Base: 70%	90% after deductible	80% after deductible
Inpatient Newborn Care	100%, no deductible	70%, no deductible	90% after deductible	70% after deductible	Base: 100% SMM: 90% after deductible	Base: 70%	90% after deductible	
Additional Services								
Ambulance (includes air if medically necessary)	$40 copayment; then 100%		90% after deductible	70% after deductible	Base: 100%	Base: 70%	90% after deductible	
Durable Medical Equipment	90%, no deductible	70% after deductible	90% after deductible	70% after deductible	SMM Only: 90% after deductible		90% after deductible	80% after deductible
Other Medical Supplies	100%, no deductible	70%, no deductible	90% after deductible	70% after deductible	SMM Only: 90% after deductible		90% after deductible	80% after deductible
Home Healthcare	100% no deductible		90% after deductible	70% after deductible	SMM Only: 90% after deductible		90% after deductible	80% after deductible
Hospice	100% no deductible		90% after deductible	70% after deductible	SMM Only: 90% after deductible		90% after deductible	80% after deductible
Human Organ Transplants	100%, no deductible	70%, no deductible	90% after deductible	70% after deductible	Base: 100% SMM Only: 90% after deductible	Base: 70%	90% after deductible	80% after deductible
Prescription Drug Deductibles & Injectible Insulin	90% after deductible		Not Covered		SMM Only: 90% after deductible		90% after deductible	
Private Duty Nursing	90%, no deductible	70% after deductible	90% after deductible	70% after deductible	SMM Only: 90% after deductible		90% after deductible	
Skilled Nursing Facility	1st 365 days, 100% no deductible. After 365 days, 90%, no deductible	70%, no deductible	90% after deductible	70% after deductible	SMM Only: 90% after deductible		90% after deductible	80% after deductible
Dental/Oral Surgery & Accident	100%, no deductible	70%, no deductible	90% after deductible	70% after deductible	SMM Only: 90% after deductible		90% after deductible	80% after deductible
TMJ Services	90%, no deductible	70% after deductible	90% after deductible	70% after deductible	Base: 100% SMM: 90% after deductible	Base: 70%	90% after deductible	80% after deductible
Mental Health and Substance Abuse								
Inpatient Mental Health and Substance Abuse Services	Covered in Full; No Deductible	70% Coinsurance; No Deductible	90% after deductible	70% after deductible	Base: 100% SMM Only: 90% after deductible	Base: 70%	90% after deductible	80% after deductible
Outpatient Mental Health and Substance Abuse Services	Benefits are based on corresponding medical benefits		90% after deductible	70% after deductible	Base: 100% SMM Only: 90% after deductible Outpt Drug Abuse only covered under SMM.	Base: 70%	90% after deductible	80% after deductible

[1] Three (3) month deductible carryover applies.

[2] The Non-Network deductible applies ONLY to Durable Medical Equipment, Office Visits, Private Duty Nursing and TMJ Services. **(NOT APPLICABLE TO PROPOSED PLAN)**

[3] The OOP limit applies ONLY to Ambulance, Emergency (accidents and medical emergencies), Urgent Care, Durable Medical Equipment, Office Visits, Private Duty Nursing, Skilled Nursing, Spinal Manipulations, Inpatient Facility Services and TMJ Services. It includes all flat dollar copayments incurred in a benefit period. **(NOT APPLICABLE TO PROPOSED PLAN)**

[4] Network and Non-Network Deductibles accumulate towards each other. However, Network and Non-Network OOP limits are separate and do not accumulate towards each other.

Disclaimer: This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Youngstown City Schools
Benefit Plan Comparison (includes Health Care Reform) with Proposed PPO Plan Options 1- 3

Network Type	**Proposed PPO Plan - OPTION 1** *Hospital & Physcian Network*		**Proposed PPO Plan - OPTION 2** *Hospital & Physcian Network*		**Proposed PPO Plan - Option 3** *Hospital & Physcian Network*	
Benefits	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Benefit Period	January 1st through December 31st		January 1st through December 31st		January 1st through December 31st	
Dependent Age Limit	Age 26; Removal upon End of Month		Age 26; Removal upon End of Month		Age 26; Removal upon End of Month	
Over Age Dependent Limit	Age 28; Removal upon End of Month (at Cardholder's Expense)		Age 28; Removal upon End of Month (at Cardholder's Expense)		Age 28; Removal upon End of Month (at Cardholder's Expense)	
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Human Organ Transplant Maximum	Unlimited		Unlimited		Unlimited	
Benefit Period Deductible - Single/Family	$50 Single/$100 Family		$50 Single/$100 Family			
Coinsurance	90%	70%	90%	70%		
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	$225 Single/$450 Family	No Limit	$225 Single/$450 Family	No Limit		
Physician/Office Services						
Office Visit (Illness/Injury)	$10 copay, then 90%	$10 copay, then 70%	90% after deductible	70% after deductible		
Urgent Care Facility Services Accident or Initial Injury care rendered within 2 days of Injury Accident or Initial Injury care rendered after 2 days of Injury Medical Emergency	$25 copay, then 100% for all urgent care	$25 copay, then 70% for all urgent care	$25 copay, then 100% for all urgent care	$25 copay, then 70% for all urgent care		
Allergy Testing	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
Allergy Treatments	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
ALL Immunizations	90%, no deductible	70%, no deductible	90%, no deductible	70%, no deductible		
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	Included Above		Included Above			
Voluntary Second Surgical Opinion	$10 copay, then 90%	$10 copay, then 70%	90% after deductible	70% after deductible		
Preventive Services						
Routine Physical Exam	$10 copay, then 100%	$10 copay; then 70%	90% no deductible	70% no deductible		
Routine OB/GYN Exam (One per benefit period)	$10 copay, then 100%	$10 copay; then 70%	90% no deductible	70% no deductible		
Well Child Care Services including Exam and Immunizations	$10 copay, then 100%; 90% no deductible all other services	$10 copay; then 70%; 70% no deductible all other services	90% no deductible	70% no deductible		
Well Child Care Laboratory Tests - Birth to Age 9	90% no deductible	70% no deductible	90% no deductible	70% no deductible		
Routine EKG, Chest X-Ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period)	90% no deductible	70% no deductible	90% no deductible	70% no deductible		
Routine Mammogram (One per benefit period)	90% no deductible	70% no deductible	90% no deductible	70% no deductible		
Routine PAP (One per benefit period)	90% no deductible	70% no deductible	90% no deductible	70% no deductible		
Routine PSA Test (One per benefit period)	90% no deductible	70% no deductible	90% no deductible	70% no deductible		
Routine Tuberculosis Tests	90% no deductible	70% no deductible	90% no deductible	70% no deductible		
Routine Colorectal or Bone Density Screening	90% no deductible	70% no deductible	90% no deductible	70% no deductible		
Routine Hearing Test & Evaluation	90% no deductible	70% no deductible	90% no deductible	70% no deductible		
Outpatient Services						
Surgical Services	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
Diagnostic Services (X-rays, Lab & Medical tests)	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
Physical / Chiropractic / Occupational Therapy (Facility and Professional) per benefit period	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
	40 visits Physical & Occupational Therapy *12 visits Chiropractic*		*40 visits Physical & Occupational Therapy* *12 visits Chiropractic*			

Network Type	**Proposed PPO Plan - OPTION 1** *Hospital & Physcian Network*		**Proposed PPO Plan - OPTION 2** *Hospital & Physcian Network*		**Proposed PPO Plan - Option 3** *Hospital & Physcian Network*	
Benefits	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Speech Therapy - Facility and Professional	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
Cardiac Rehabilitation	*20 visits for Speech Therapy*		*20 visits for Speech Therapy*			
Professional Medical Services	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
Emergency use of an Emergency Room						
Accident or Initial Injury care rendered within 2 days of Injury Accident or Initial Injury care rendered after 2 days of Injury Medical Emergency	$50 copay, then 100% for accident or med emergency Copay waived if admitted	$50 copay, then 100% accident or med emergency Copay waived if admitted	$50 copay, then 100% for accident or med emergency Copay waived if admitted	$50 copay, then 100% accident or med emergency Copay waived if admitted		
Non-Emergency Use of ER	$50 copay, then 90%	$50 copay, then 70%	$50 copay, then 90%	$50 copay, then 70%		
Supplemental Accident Care (Limited to the first $300 of services received within 90 days after an accident)	First $300 covered at 100%, then		First $300 covered at 100%, then			
Inpatient Facility	90% after deductible	80% after deductible	90% after deductible	80% after deductible		
Semi-Private Room and Board	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
Inpatient Consultations	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
Maternity	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
Inpatient Newborn Care	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
Additional Services						
Ambulance (includes air if medically necessary)	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
Durable Medical Equipment	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
Other Medical Supplies	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
Home Healthcare	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
Hospice	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
Human Organ Transplants	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
Prescription Drug Deductibles & Injectible Insulin	Not Covered		Not Covered			
Private Duty Nursing	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
Skilled Nursing Facility	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
Dental/Oral Surgery & Accident						
TMJ Services	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
Mental Health and Substance Abuse						
Inpatient Mental Health and Substance Abuse Services	90% after deductible	70% after deductible	90% after deductible	70% after deductible		
Outpatient Mental Health and Substance Abuse Services	90% after deductible or $10 copay then 90% if office visit	70% after deductible or $10 copay then 70% if office visit	90% after deductible	70% after deductible		

[1] Three (3) month deductible carryover applies.

[2] The Non-Network deductible applies ONLY to Durable Medical Equipment, Office Visits, Private Duty Nursing and TMJ Services. **(NOT APPLICABLE TO PROPOSED PLAN)**

[3] The OOP limit applies ONLY to Ambulance, Emergency (accidents and medical emergencies), Urgent Care, Durable Medical Equipment, Office Visits, Private Duty Nursing, Skilled Nursing, Spinal Manipulations, Inpatient Facility Services and TMJ Services. It includes all flat dollar copayments incurred in a benefit period. **(NOT APPLICABLE TO PROPOSED PLAN)**

[4] Network and Non-Network Deductibles accumulate towards each other. However, Network and Non-Network OOP limits are separate and do not accumulate towards each other.