CLE Care 3020-2000 w/Rx
Illustrative Summary of Benefits

Effective 5/1/2021

Benefits	Network
Benefit Period	January 1st through December 31st
Dependent Age Limit	26 - Removal upon End of the Month
Deductible (Single / Family)	$2,000 / $4,000
Coinsurance Max. Out-of-Pocket (excl. ded) (Single / Family)	$5,000 / $10,000
Maximum Out-of-Pocket (Single / Family)[1]	$7,000 / $14,000
Coinsurance (member cost)	20%
Physician/Office Services	
Physician Office Visit	$30 copay then 0%
Specialist Office Visit	$60 copay then 0%
Urgent Care Office Visit	$30 copay then 0%
Emergency Services	
Emergency Use of an Emergency Room	20% coinsurance after $350 copay
Emergency Services (expenses other than Emergency Room)	20% coinsurance after network deductible
Non-Emergency Use of an Emergency Room	Not Covered
Routine/Preventive Services[2]	
Health Care Reform Benefits	0%
Health Care Reform Benefits for Women	0%
All Immunizations	0%
Routine Physical Exam (age 21 and over)	0%
Routine Mammogram (one per benefit period)	0%
Routine Pap Test	0%
Routine Lab, Medical Tests, and X-rays	0%
Routine Endoscopic Services	0%
Well Child Care (to age 21)	
Well Child Care Exams, Immunizations and Labs	0%
Hearing Exams	0%
Vision Exams	0%
Lenses	Not Covered
Frames	Not Covered
Contacts	Not Covered
Outpatient Services	
Allergy Testing and Treatments	coinsurance after deductible
Physical & Occupational Therapies (40 visits per benefit period/combined)	coinsurance after deductible
Speech Therapy (20 visits per benefit period)	coinsurance after deductible
Chiropractic Services (12 visits per benefit period)	coinsurance after deductible
Cardiac Rehabilitation (36 visits per benefit period)	coinsurance after deductible
Surgical Services	coinsurance after deductible
Diagnostic Lab, Medical Tests, and X-rays	coinsurance after deductible
Diagnostic Imaging	coinsurance after deductible
Diagnostic Endoscopic Services	0%
Inpatient Services	
Institutional Services	coinsurance after deductible
Maternity	coinsurance after deductible
Skilled Nursing Facility (90 days per benefit period)	coinsurance after deductible

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Additional Services				
Ambulance	coinsurance after $50 copay			
Diabetic Education and Training	coinsurance after deductible, unless the service is covered under Health Care Reform Preventive Benefits			
Durable Medical Equipment	coinsurance after deductible			
DME - Wigs	Not Covered			
Home Health Care (100 visits per benefit period)	coinsurance after deductible			
Hospice	coinsurance after deductible			
Organ and Tissue Transplants	coinsurance after deductible			
Organ Transplant Services (includes travel, meals, lodging and transportation)	coinsurance after deductible			
Private Duty Nursing	coinsurance after deductible			
Sterilization	coinsurance after deductible			
Mental Health & Substance Abuse - Federal Mental Health Parity				
Inpatient Mental Health and Substance Abuse Services	Benefits paid are based on corresponding medical benefits			
Outpatient Mental Health and Substance Abuse Services				
Prescription Drug Benefits[3]				
ESI National Plus Network			MetroHealth Pharmacies	
Retail only:	Mail:		Retail:	Mail:
(up to 30-day supply) Generic: $15 copay; Preferred Brand: $45 copay; Non-Preferred Brand: $75 copay; Specialty High-Cost Drugs*: 50% up to max of $200	Not applicable Must use MetroHealth Pharmacy		(up to 30-day supply): Generic: $7.50 copay; Preferred Brand: $22.50 copay; Non-Preferred Brand: $37.50 copay; Specialty High-Cost Drugs*: 50% up to max of $200	(up to 90-day supply) Generic: $22.50 copay; Preferred Brand: $67.50 copay; Non-Preferred Brand: $112.50 copay;

[1]Network level Out-of-Pocket includes deductible and coinsurance and flat dollar copayments.

[2]Preventive services include evidence-based services that have a rating of “A” or “B” in the United States Preventive Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.

[3]**Generic Incentive:** If a brand-name drug is requested when a generic equivalent exists, the member pays the brand-name copay plus the difference between the cost of the generic drug and the brand-name drug.
Specialty High-Cost Drugs Must be filled by MetroHealth, Accredo or Gentry.

The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual case manager (except for corneal transplants.) Failure to contact the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

Benefits will be administered by Medical Mutual of Ohio. Benefits will be determined based on Medical Mutual's medical and administrative policies and procedures. This document is only a partial listing of benefits. This is not a contract of insurance. Only an officer of Medical Mutual may agree, orally or in writing, to change the benefits listed here. The contract or certificate will contain the complete listing of covered services. In certain instances, Medical Mutual’s payment may not equal the percentage listed above. However, the covered person’s coinsurance will always be based on the lesser of the provider’s billed charges or Medical Mutual’s negotiated rate with the provider.