



30-1000 w/Rx
Illustrative Summary of Benefits



Effective 5/1/2022

| Benefits | Network | Non-Network |
|---|---|------------------------------|
| Benefit Period | January 1 st through December 31 st | |
| Dependent Age Limit | 26 - Removal upon End of the Month | |
| Deductible (Single / Family) | \$1,000 / \$3,000 | \$2,000 / \$6,000 |
| Coinsurance Max. Out-of-Pocket (excl. ded) (Single / Family) | N/A | \$10,000 / \$20,000 |
| Maximum Out-of-Pocket (Single / Family) ¹ | \$6,600 / \$13,200 | \$12,000 / \$26,000 |
| Coinsurance (member cost) | 0% | 50% |
| Physician/Office Services | | |
| Physician Office Visit | \$30 copay then 0% | coinsurance after deductible |
| Specialist Office Visit | \$60 copay then 0% | coinsurance after deductible |
| Urgent Care Office Visit | \$75 copay then 0% | coinsurance after deductible |
| Emergency Services | | |
| Emergency Use of an Emergency Room | network coinsurance after \$350 copay | |
| Emergency Services (expenses other than Emergency Room) | network coinsurance after deductible | |
| Non-Emergency Use of an Emergency Room | Not Covered | |
| Routine/Preventive Services² | | |
| Health Care Reform Benefits | 0% | coinsurance after deductible |
| Health Care Reform Benefits for Women | 0% | coinsurance after deductible |
| All Immunizations | 0% | coinsurance after deductible |
| Routine Physical Exam (age 21 and over) | 0% | coinsurance after deductible |
| Routine Mammogram (one per benefit period) | 0% | coinsurance after deductible |
| Routine Pap Test (one per benefit period) | 0% | coinsurance after deductible |
| Routine Lab, Medical Tests, and X-rays | 0% | coinsurance after deductible |
| Routine Endoscopic Services | 0% | coinsurance after deductible |
| Well Child Care (to age 21) | | |
| Well Child Care Exams, Immunizations and Labs | 0% | coinsurance after deductible |
| Hearing Exams | 0% | coinsurance after deductible |
| Vision Exams | 0% | coinsurance after deductible |
| Lenses | Not Covered | Not Covered |
| Frames | Not Covered | Not Covered |
| Contacts | Not Covered | Not Covered |
| Outpatient Services | | |
| Allergy Testing and Treatments | coinsurance after deductible | coinsurance after deductible |
| Physical & Occupational Therapies (40 visits per benefit period/combined) | coinsurance after deductible | coinsurance after deductible |
| Speech Therapy (20 visits per benefit period) | coinsurance after deductible | coinsurance after deductible |
| Chiropractic Services (12 visits per benefit period) | coinsurance after deductible | coinsurance after deductible |
| Cardiac Rehabilitation (36 visits per benefit period) | coinsurance after deductible | coinsurance after deductible |
| Surgical Services | coinsurance after deductible | coinsurance after deductible |
| Diagnostic Lab, Medical Tests, and X-rays | coinsurance after deductible | coinsurance after deductible |
| Diagnostic Imaging | coinsurance after deductible | coinsurance after deductible |
| Diagnostic Endoscopic Services | 0% | coinsurance after deductible |
| Inpatient Services | | |
| Institutional Services | coinsurance after deductible | coinsurance after deductible |
| Maternity | coinsurance after deductible | coinsurance after deductible |
| Skilled Nursing Facility (90 days per benefit period) | coinsurance after deductible | coinsurance after deductible |



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|--|--|------------------------------|
| Additional Services | | |
| Ambulance | coinsurance after \$50 copay | coinsurance after \$50 copay |
| Autism Spectrum Disorders (benefits payable for the screening, diagnosis and treatment for Eligible Dependent children under the age of fourteen (14)). | Speech and language therapy: 20 visits per Benefit Period Occupational Therapy: 20 visits per Benefit Period Clinical therapeutic intervention: 20 hours per week | coinsurance after deductible |
| Diabetic Education and Training | coinsurance after deductible, unless the service is covered under Health Care Reform Preventive Benefits | coinsurance after deductible |
| Durable Medical Equipment | coinsurance after deductible | coinsurance after deductible |
| DME - Wigs | Not Covered | Not Covered |
| Home Health Care (100 visits per benefit period) | coinsurance after deductible | coinsurance after deductible |
| Hospice | coinsurance after deductible | coinsurance after deductible |
| Organ and Tissue Transplants | coinsurance after deductible | coinsurance after deductible |
| Organ Transplant Services (includes travel, meals, lodging and transportation) | Not Covered | Not Covered |
| Private Duty Nursing (90 days per benefit period) | coinsurance after deductible | coinsurance after deductible |
| Sterilization | coinsurance after deductible | 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 Benefits³ | | |
| Network Pharmacy / Retail (30 day supply) | Generic: \$15 copay; Preferred Brand: \$45 copay; Non-Preferred Brand: \$75 copay; Specialty High-Cost Drugs: \$275 copay | |
| Home Delivery / Contracted Provider (90 day supply) (Specialty drugs limited to 30 day supply) | Generic: \$45 copay; Preferred Brand: \$135 copay; Non-Preferred Brand: \$225 copay; Specialty High-Cost Drugs: \$275 copay | |

•Network level Out-of-Pocket includes deductible and coinsurance and flat dollar copayments.

•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.

•**Generic Incentive** applies - Brand copay + price difference between brand and generic; Will not apply to MOOP.

Home Delivery Incentive applies - 2x retail copay penalty on freestanding Rx plans. 100% coinsurance for 4th retail fill in 180 days for MMRX plans with >0% member coinsurance. Applies to MOOP.

Specialty High-Cost Drugs - Drugs and Biologicals (Specialty Drugs and Therapeutic Injections) - Mail order 30 day supply is included, Exclusive Specialty Network. Special rules apply to Oral Chemotherapy prescription drugs, please refer to your benefit booklet.

Deductible expenses incurred for services by a PPO Network provider will only apply to the PPO Network deductible. Deductible expenses incurred for services by a Non PPO Network provider will only apply to the Non PPO Network deductible.

The coinsurance for non-contracting institutional providers will be the same coinsurance percentage as the Non PPO Network provider. However, you may be subject to balance billing by the non-contracting provider.

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.