# Illustrative Summary of Benefits

## Health Savings Account Compatible

**Effective 5/1/2020**

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Network</th>
<th>Non Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefit Period</strong></td>
<td>January 1st through December 31st</td>
<td></td>
</tr>
<tr>
<td><strong>Dependent Age Limit</strong></td>
<td>26 - Removal upon End of the Month</td>
<td></td>
</tr>
<tr>
<td><strong>Deductible (Single / Family)</strong></td>
<td>$4,000 / $8,000</td>
<td>$8,000 / $16,000</td>
</tr>
<tr>
<td><strong>Maximum Out-of-Pocket (Single / Family)</strong></td>
<td>$6,900 / $13,800</td>
<td>$13,000 / $26,000</td>
</tr>
<tr>
<td><strong>Coinsurance (member cost)</strong></td>
<td>0%</td>
<td>40%</td>
</tr>
</tbody>
</table>

### Physician/Office Services

- **Physician Office Visit**: coinsurance after deductible
- **Specialist Office Visit**: coinsurance after deductible
- **Urgent Care Office Visit**: coinsurance after deductible

### Emergency Services

- **Emergency Use of an Emergency Room**: coinsurance after network deductible
- **Emergency Services (expenses other than Emergency Room)**: coinsurance after network deductible
- **Non-Emergency Use of an Emergency Room**: Not Covered

### Routine/Preventive Services

- **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 (one per benefit period)**: 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
Additional Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Network</th>
<th>Non Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td>coinsurance after deductible</td>
<td>coinsurance after deductible</td>
</tr>
<tr>
<td>Diabetic Education and Training</td>
<td>coinsurance after deductible, unless the service is covered under Health Care Reform Preventive Benefits</td>
<td>coinsurance after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>coinsurance after deductible</td>
<td>coinsurance after deductible</td>
</tr>
<tr>
<td>DME - Wigs</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Home Health Care (100 visits per benefit period)</td>
<td>coinsurance after deductible</td>
<td>coinsurance after deductible</td>
</tr>
<tr>
<td>Hospice</td>
<td>coinsurance after deductible</td>
<td>coinsurance after deductible</td>
</tr>
<tr>
<td>Organ and Tissue Transplants</td>
<td>coinsurance after deductible</td>
<td>coinsurance after deductible</td>
</tr>
<tr>
<td>Organ Transplant Services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Private Duty Nursing (90 days per benefit period)</td>
<td>coinsurance after deductible</td>
<td>coinsurance after deductible</td>
</tr>
<tr>
<td>Sterilization</td>
<td>coinsurance after deductible</td>
<td>coinsurance after deductible</td>
</tr>
</tbody>
</table>

Mental Health & Substance Abuse - Federal Mental Health Parity

Inpatient Mental Health and Substance Abuse Services

Outpatient Mental Health and Substance Abuse Services

Benefits paid are based on corresponding medical benefits

Prescription Drug Benefits

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Network Pharmacy / Retail (30 day supply)</th>
<th>Home Delivery / Contracted Provider (90 day supply) (Specialty drugs limited to 30 day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Generic: $15 copay after deductible; Preferred Brand: $45 copay after deductible; Non-Preferred Brand: $75 copay after deductible; Specialty High-Cost Drugs: 50% up to max of $200 after deductible</td>
<td>Generic: $45 copay after deductible; Preferred Brand: $135 copay after deductible; Non-Preferred Brand: $225 copay after deductible; Specialty High-Cost Drugs: 50% up to max of $200 after deductible</td>
</tr>
</tbody>
</table>

Network level Out-of-Pocket includes deductible, 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.