Illustrative Summary of Benefits

COSE Benefit Plan 20-3000 Rx

New business and renewals effective 1.1.27 and after

	Network	Non-Network
Benefits	**Member Pays**	
Benefit Period	January 1st through December 31st	
Dependent Age Limit	26—Removal upon End of the Month	
Deductible - Single / Family	$3,000 / $6,000	$4,000 / $8,000
Coinsurance Out-of-Pocket (excludes deductible) - Single / Family	$0 / $0	$10,000 / $20,000
Maximum Out-of-Pocket - Single / Family[1]	$8,000 / $16,000	$14,000 / $28,000
Coinsurance	0%	50%
Physician/Office Services		
Physician Office Visit (and On Demand Virtual Telehealth)	$20 copay then 0%	Coinsurance after deductible
Preferred On Demand Telehealth (Minute Clinic®)	$0 copay then 0%	Coinsurance after deductible
Specialist Office Visit	$40 copay then 0%	Coinsurance after deductible
Urgent Care Office Visit	$60 copay then 0%	Coinsurance after deductible
Emergency Services		
Emergency Use of an Emergency Room	Deductible, then $500 copay	
Emergency Services (expenses other than Emergency Room)	Coinsurance after deductible	
Emergency Room Physician	Coinsurance after deductible	
Routine/Preventive Services[2]		
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 Labs, 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
Outpatient Services		
Allergy Testing and Treatments	Coinsurance after deductible	Coinsurance after deductible
Physical & Occupational Therapies (40 visits per benefit period/combined)	$20 copay then 0%	Coinsurance after deductible
Speech Therapy (20 visits per benefit period)	Coinsurance after deductible	Coinsurance after deductible
Chiropractic Services (12 visits per benefit period)	$20 copay then 0%	Coinsurance after deductible
Cardiac Rehabilitation (36 visits per benefit period)	Coinsurance after deductible	Coinsurance after deductible
Respiratory Therapy	Coinsurance after deductible	Coinsurance after deductible
Surgical Services	Coinsurance after deductible	Coinsurance after deductible
Diagnostic Lab	Coinsurance after deductible	Coinsurance after deductible
Diagnostic X-rays	Coinsurance after deductible	Coinsurance after deductible
Diagnostic Imaging (CT/PET scans and MRI's)	Coinsurance after deductible	Coinsurance after deductible
Diagnostic Endoscopic Services	0%	Coinsurance after deductible
Inpatient Services		
Institutional Services (per stay)	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

	Network	Non-Network
Additional Services		
Ambulance	Coinsurance after $50 copay	Coinsurance after $50 copay
Autism Spectrum Disorders	Benefits paid are based on services rendered	
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
Hearing Conformity and Hearing Aid Evaluation Test (age 21 and under)	0%	Coinsurance after deductible
Home Health Care (100 visits per benefit period)	Coinsurance after deductible	Coinsurance after deductible
Hospice	Coinsurance after deductible	Coinsurance after deductible
Medical Supplies	Coinsurance after deductible	Coinsurance after deductible
Organ and Tissue Transplants	Coinsurance after deductible	Coinsurance after deductible
Private Duty Nursing (90 days per benefit period)	Coinsurance after deductible	Coinsurance after deductible
Standard Hearing Aid (1 per ear every 48 months, limited to $2,500 per aid) (age 21 and under)	0%	Coinsurance after deductible
Mental Health & Substance use—Federal Mental Health Parity		
Inpatient Mental Health and Substance use Services	Benefits paid are based on corresponding medical benefits	
Outpatient Mental Health and Substance use Services	Benefits paid are based on corresponding medical benefits	
Non-Covered Services		
Well Child: Lenses, Frames, Contacts	Not covered	Not covered
ER: Non-Emergency use of Emergency Room	Not covered	Not covered
Other: Abortions - Elective, Acupuncture, Bariatric Surgery, Cosmetic Services, Dental Care (adult), Hearing Aids age 22+, Infertility Treatment, Long Term Care, Non-Emergency outside U.S., Routine Eye care (adult), Routine Foot Care, Weight Loss Programs, Organ Transplant Services (includes travel, meals, lodging and transportation), After Hours Care, Wigs	Not covered	Not covered
Prescription Drug Benefits[3] (National Plus Network and Basic Plus Formulary)		
Retail (30-day supply)	Generic Preferred Brand Non-Preferred Brand	$10 copay $30 copay $50 copay
Home Delivery (90-day supply)	Generic Preferred Brand Non-Preferred Brand	$30 copay $90 copay $150 copay
Specialty drugs (limited to 30-day supply)	Specialty Drugs	$250 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 Applies**
When a generic equivalent is available, members choosing the brand-name drug pay the brand cost plus the difference in cost between the brand and generic (copay, when applicable). This amount does not count toward MOOP and remains applicable after MOOP is met.

Home Delivery Incentive Applies
Retail drug copays apply for the first three fills in 180 days. Starting on the 4th fill, Copay amount doubles unless mail order is used.

Specialty Drugs
Drugs and biologicals (specialty drugs and therapeutic injections). Members must use one of our dedicated pharmacies. Special rules apply to oral chemotherapy prescription drugs. The certificate booklet will have more information. Certain specialty drugs are part of a Specialty Prescription Drug Copay Offset program (SaveOn) where they are considered non-essential health benefits and therefore do not apply to the maximum out-of-pocket. They will also be subject to higher cost-share if the member does not participate in SaveOn. Once enrolled in the Medical Mutual health plan, call 1-800-683-1074 to enroll in copay assistance, with SaveOnSP monitoring, so that your responsibility could be as low as $0

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.