Illustrative Summary of Benefits

COSE BP CLE-Care 3020-1000 Rx

New business and renewals effective 8/1/24 and after

	Network	Non-Network
Benefits		
Benefit Period	January 1st through December 31st	
Dependent Age Limit	26—Removal upon End of the Month	
Deductible (Single / Family)	$1,000 / $2,000	N/A
Coinsurance Out-of-Pocket (Single / Family)	$5,500 / $11,000	N/A
Maximum Out-of-Pocket (Single / Family)[1]	$6,500 / $13,000	N/A
Coinsurance	20%	N/A
Physician/Office Services		
Physician Office Visit	$30 copay then 0%	N/A
Specialist Office Visit	$60 copay then 0%	N/A
Urgent Care Office Visit (must use Metro Express location)	$30 copay then 0%	N/A
Emergency Services		
Emergency Use of an Emergency Room	Deductible, then $500 copay, then 0%	
Emergency Services (expenses other than Emergency Room)	20% after deductible	
Non-Emergency Use of an Emergency Room	Not covered	
Routine/Preventive Services[2]		
Health Care Reform Benefits	0%	N/A
Health Care Reform Benefits for Women	0%	N/A
All Immunizations	0%	N/A
Routine Physical Exam (age 21 and over)	0%	N/A
Routine Mammogram (one per benefit period)	0%	N/A
Routine Pap Test (one per benefit period)	0%	N/A
Routine Lab, Medical Tests, and X-rays	0%	N/A
Routine Endoscopic Services	0%	N/A
Well Child Care (to age 21)		
Well Child Care Exams, Immunizations and Labs	0%	N/A
Hearing Exams	0%	N/A
Vision Exams	0%	N/A
Lenses	Not covered	N/A
Frames	Not covered	N/A
Contacts	Not covered	N/A
Outpatient Services		
Allergy Testing and Treatments	Coinsurance after deductible	N/A
Physical & Occupational Therapies (40 visits per benefit period/combined)	Coinsurance after deductible	N/A
Speech Therapy (20 visits per benefit period)	Coinsurance after deductible	N/A
Chiropractic Services (12 visits per benefit period)	Coinsurance after deductible	N/A
Cardiac Rehabilitation (36 visits per benefit period)	Coinsurance after deductible	N/A
Surgical Services	Coinsurance after deductible	N/A
Diagnostic Lab, Medical Tests, and X-rays	Coinsurance after deductible	N/A
Diagnostic Imaging	Coinsurance after deductible	N/A
Diagnostic Endoscopic Services	0%	N/A
Inpatient Services		
Institutional Services	Coinsurance after deductible	N/A
Maternity	Coinsurance after deductible	N/A
Skilled Nursing Facility (90 days per benefit period)	Coinsurance after deductible	N/A

	Network	Non-Network
Additional Services		
Ambulance	Coinsurance after $50 copay	N/A
Autism Spectrum Disorders	Benefits paid are based on services	N/A
Diabetic Education and Training	Coinsurance after deductible, unless the service is covered under Health Care Reform Preventive Benefits	N/A
Durable Medical Equipment	Coinsurance after deductible	N/A
DME—Wigs	Not covered	N/A
Home Health Care (100 visits per benefit period)	Coinsurance after deductible	N/A
Hospice	Coinsurance after deductible	N/A
Organ and Tissue Transplants	Coinsurance after deductible	N/A
Organ Transplant Services (includes travel, meals, lodging and transportation)	Coinsurance after deductible	N/A
Private Duty Nursing (90 days per benefit period)	Coinsurance after deductible	N/A
Sterilization	Coinsurance after deductible	N/A
Mental Health & Substance Abuse—Federal Mental Health Parity		
Inpatient Mental Health and Substance Abuse Services	Benefits paid are based on corresponding medical benefits	N/A
Outpatient Mental Health and Substance Abuse Services	Benefits paid are based on corresponding medical benefits	N/A
Prescription Drug Benefits[3] MetroHealth Pharmacies		
Generic / Preferred / Non-preferred - Retail	$5 / $15 / $30	
Generic / Preferred / Non-preferred - Mail order	$15 / $45 / $90	
Prescription Drug Benefits Express Scripts Pharmacies		
Generic / Preferred / Non-preferred / Specialty* No Mail order available -must use MetroHealth Pharmacies	$10 / $45 / $95 / $350	

1 Network level Maximum 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**
If a brand-name drug is requested when a generic equivalent exists, the member pays the brand-name copay plus the difference between to cost of the generic and the brand-name drug. Will not apply to maximum out-of-pocket

***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.