

Illustrative Summary of Benefits

COSE BP CLE-Care HSA 5000/20 MMRx

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



	Network	Non-Network
Benefits		
Benefit Period	January 1 st through December 31 st	
Dependent Age Limit	26—Removal upon End of the Month	
Deductible (Single / Family)	\$5,000 / \$10,000	N/A
Coinsurance Out-of-Pocket (Single / Family)	\$2,500 / \$5,000	N/A
Maximum Out-of-Pocket (Single / Family) ¹	\$7,500 / \$15,000	N/A
Coinsurance	20%	N/A
Physician/Office Services		
Physician Office Visit	Coinsurance after deductible	N/A
Specialist Office Visit	Coinsurance after deductible	N/A
Urgent Care Office Visit (must use Metro Express location)	Coinsurance after deductible	N/A
Emergency Services		
Emergency Use of an Emergency Room	Coinsurance after deductible	
Emergency Services (expenses other than Emergency Room)	Coinsurance 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	Coinsurance after deductible	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 deductible	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		Coinsurance after deductible	
Generic / Preferred / Non-preferred - Mail order		Coinsurance after deductible	
Prescription Drug Benefits		Express Scripts Pharmacies	
Generic / Preferred / Non-preferred / Specialty* No mail order available -must use MetroHealth Pharmacies		Coinsurance after deductible	
National Plus Network, Basic Plus Formulary			
Pharmacy copays apply after deductible			

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 the 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.