



MedFlex HSA 5,000 w/ PD Rx**
Illustrative Summary of Benefits
Health Savings Account Compatible
 Effective 7/1/2023



| Benefits | Network |
|--|---|
| 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 |
| Coinsurance Max. Out-of-Pocket (excl. ded) (Single / Family) | N/A |
| Maximum Out-of-Pocket (Single / Family) ¹ | \$6,900 / \$13,800 |
| Coinsurance (member cost) | 0% |
| 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 Services² | |
| 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 | 0% |
| Routine Lab, Medical Tests, and X-rays | 0% |
| Routine Endoscopic Services | 0% |
| Well Child Care (to age 21)³ | |
| 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 |
| Medically Necessary Colonoscopy, Sigmoidoscopy, Anoscopy and Proctosigmoidoscopy | 0% |
| Inpatient Services | |
| Institutional Services | coinsurance after deductible |
| Maternity | coinsurance after deductible |
| Skilled Nursing Facility (90 days per benefit period) | coinsurance after deductible |



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| Additional Services | |
| Ambulance | coinsurance after deductible |
| Diabetic Education and Training | coinsurance after deductible, unless the service is covered under Health Care Reform Preventive Benefits |
| Durable Medical Equipment | coinsurance after deductible |
| DME - Wigs | Not Covered |
| Home Health Care (100 visits per benefit period) | coinsurance after deductible |
| Hospice | coinsurance after deductible |
| Organ and Tissue Transplants | coinsurance after deductible |
| Organ Transplant Services (includes travel, meals, lodging and transportation) | coinsurance after deductible |
| Private Duty Nursing | coinsurance after deductible |
| Sterilization | 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 Benefits⁴ | |
| Network Pharmacy / Retail (30 day supply) | 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* |
| Home Delivery / Contracted Provider (90 day supply) (Specialty drugs limited to 30 day supply) | 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 |

¹Network level Out-of-Pocket includes deductible, coinsurance and flat dollar copayments.

²Preventive 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.

³Access to pediatric care and specialists at in-network children's hospitals is limited to children under age 20.

⁴**Generic Incentive:** 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 drug and the brand-name drug.

Mail-Order Requirement: Prescriptions must be filled by mail-order (when available) after the third fill within 180 days. Otherwise, the member pays the full cost of the drug.

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 (SaveOnSP Exclusive) where they are considered non-essential health benefits and therefore do not apply to the out-of-pocket maximum. They will also be subject to higher cost-share if the member does not participate in SaveOnSP Exclusive.

-For a list of Specialty drugs that are potentially eligible for \$0 copay, visit [SaveOnSP Exclusive](#)

**The HSA plan has post-deductible drug copays. Amounts only apply after the deductible is met.

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.