



MEDICAL MUTUAL®



# MedMutual Market Classic 1000 Gold

Benefit Period: January 1 (or member's plan effective date) through December 31

Member Pays

Benefit	In-Network	Non-Network
<b>Deductible</b>	\$1,000 Single; \$2,000 Family	\$3,000 Single; \$6,000 Family
<b>Maximum Out-of-Pocket (MOOP)</b> <i>Network Only: deductibles, copays, including prescription drug copays and coinsurance</i>	\$5,000 Single; \$10,000 Family	Unlimited
<b>Accumulation Method<sup>1</sup></b>	Embedded <sup>1</sup>	
<b>Coinsurance</b> <i>Amount paid by a member after the deductible is satisfied</i>	20%	50%
<b>Overall Annual Benefit Period Max</b>	Unlimited	
<b>Dependent Age</b>	Reach Age 28, Remove at End of Month	
<b>Benefit Period</b>	January 1st through December 31st	
<b>Physician/Office Services</b>		
Primary Care Physician Office Visits	\$25 copay; 0% after	50% after deductible
Specialists and Urgent Care Office Visits	\$50 copay; 0% after	50% after deductible
<b>Preventive Services</b>		
Preventive Services Covered under <a href="#">PPACA</a>	0%	50% after deductible
Preventive Labs, X-rays and Medical Tests (Non-PPACA)	20% after deductible	50% after deductible
Preventive Immunizations (Non-PPACA)	20% after deductible	50% after deductible
Preventive Endoscopic Service (Non-PPACA)	20% after deductible	50% after deductible
Preventive Prostate Specific Antigen (PSA)	20% after deductible	50% after deductible
Pediatric Vision (Eye Exam up to age 19)	0%	50% after deductible
Pediatric Vision Hardware (Up to age 19) Lenses and Frames or Contacts in lieu of lenses (1/benefit period)	20% after deductible	50% after deductible
Routine Physical Exams	0%	50% after deductible
Well Child Office Visits (Well Child Care up to age 21)	0%	50% after deductible
<b>Outpatient Services</b>		
Allergy Testing	20% after deductible	50% after deductible
Diagnostic Endoscopic Services (proctosigmoidoscopy, sigmoidoscopy, anoscopy, colonoscopy)	20% after deductible	50% after deductible
Diagnostic Lab	20% after deductible	50% after deductible
Emergency Use of the Emergency Room	\$250 copay; 0% after	
Emergency Physician & Ancillary Services	20% after deductible	
Non-emergency use of the Emergency Room	Not Covered	
Speech Therapy—Habilitation (20 visits/benefit period)	20% after deductible	50% after deductible
Occupational & Physical Therapy (combined 40 visits/benefit period)	20% after deductible	50% after deductible
Cardiac Rehabilitation (36 visits per benefit period)	20% after deductible	50% after deductible
Chiropractic Services (12 visits/benefit period)	20% after deductible	50% after deductible
Pulmonary Therapy (20 visits/benefit period)	20% after deductible	50% after deductible
Surgery	20% after deductible	50% after deductible
Mental Health & Substance Abuse Office Visits	\$25 copay; 0% after	50% after deductible

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## Member Pays

Benefit	In-Network	Non-Network
<b>Inpatient Services</b>		
Semi-Private Room and Board	20% after deductible	50% after deductible
Maternity/Obstetrics/Delivery	20% after deductible	50% after deductible
Mental Health & Substance Abuse	20% after deductible	50% after deductible
Physical Rehabilitation (60 days per benefit period)	20% after deductible	50% after deductible
Skilled Nursing Facility (90 days per benefit period)	20% after deductible	50% after deductible
Surgery	20% after deductible	50% after deductible
<b>Additional Services</b>		
Ambulance	20% after deductible	50% after deductible
Durable Medical Equipment and Medical Supplies	20% after deductible	50% after deductible
Home Health Services (100 visits per benefit period)	20% after deductible	50% after deductible
Hospice Services	20% after deductible	50% after deductible
Diagnostic Imaging (CT/PET Scans and MRI's)	20% after deductible	50% after deductible
Organ Transplants	20% after deductible	50% after deductible
Private Duty Nursing	20% after deductible	50% after deductible
<b>Prescription Drugs<sup>2</sup></b>		
Generic	In-Network Retail: \$15 copay for up to a 30-day supply In-Network Mail Order: \$45 copay for up to a 90-day supply	
Preferred Brand	In-Network Retail: \$30 copay for up to a 30-day supply In-Network Mail Order: \$90 copay for up to a 90-day supply	
Non-Preferred Brand Drugs	In-Network Retail: \$50 copay for up to a 30-day supply In-Network Mail Order: \$150 copay for up to a 90-day supply	
Specialty High-Cost Drugs	In-Network Retail: 20% up to a \$150 maximum per script In-Network Mail Order: 20% up to a \$450 maximum per script	

### Notes

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. No person other than 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.

Deductible and coinsurance expenses incurred for services by a network provider will only apply to the network deductible and coinsurance out-of-pocket. Deductible and coinsurance expenses incurred for services by a non-network provider will only apply to the non-network deductible and coinsurance out-of-pocket.

The coinsurance for non-contracting institutional providers will be the same coinsurance percentage as the non-network provider. However, you may be billed the remaining amount by the non-contracting provider.

The proposed course of treatment for organ transplants must be pre-authorized and approved by Medical Mutual. Failure to obtain this will result in a penalty. In the event that authorization by Medical Mutual is not received, and the organ transplant is deemed not medically necessary or is deemed to be experimental/investigational, the recipient may be responsible for all billed charges for the organ transplant.

### Footnotes

#### 1. Embedded Accumulation:

Deductible: Any combination of family members may satisfy the family deductible; however, if one family member meets the individual amount, services will begin to pay for that particular family member. Maximum out-of-pocket (MOOP): Any combination of family members may satisfy the family MOOP and services will pay at 100%. However, if one family member meets the individual amount, services will begin to pay at 100% for that particular family member only.

#### 2. Drug benefit contains the following:

- Prescription drug coverage will be subject to a formulary.
- Generic Incentive: If the member or physician requests a brand-name drug and a generic equivalent exists, the member pays the generic copayment plus the difference between the cost of the generic drug and the brand-name drug.
- Home Delivery Incentive: When a member chooses to fill a prescription a fourth time at a retail pharmacy within 180 days, the member will pay twice the normal retail copayment.
- If a non-network pharmacy is used, please refer to your Certificate Book for information about how a member will be reimbursed.