MEDICAL MUTUAL®

MedMutual 1750

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

	Member Pays	
Benefit	**In-Network**	**Non-Network**
Deductible	$1,750 Single $3,500 Family[1]	$5,250 Single $10,500 Family[1]
Maximum Out-of-Pocket (MOOP) Includes: deductibles, copays, including prescription drug copays and coinsurance	$6,850 Single $13,700 Family[1]	$100,000 Single $200,000 Family[1]
Accumulation Method[1]	Embedded[1]	
Coinsurance Amount paid by a member after the deductible is satisfied	25%	50%
Overall Annual Benefit Period Max	Unlimited	
Dependent Age	Reach Age 26, Remove at End of Month	
Benefit Period	January 1st through December 31st	
Physician/Office Services		
Primary Care Physician Office Visits	$30 copay; 25% after	50% after deductible
Specialists and Urgent Care Office Visits	$60 copay; 25% after	50% after deductible
Preventive Services		
Preventive Services Covered under PPACA	0%	50% after deductible
Preventive Labs, X-rays and Medical Tests (Non-PPACA)	25% after deductible	50% after deductible
Preventive Immunizations (Non-PPACA)	25% after deductible	50% after deductible
Preventive Endoscopic Service (Non-PPACA)	25% after deductible	50% after deductible
Preventive Prostate Specific Antigen (PSA)	25% 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)	25% 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
Outpatient Services		
Allergy Testing	25% after deductible	50% after deductible
Cardiac Rehabilitation (36 visits per benefit period)	25% after deductible	50% after deductible
Chiropractic Services (12 visits/benefit period)	25% after deductible	50% after deductible
Diagnostic Endoscopic Services (proctosigmoidoscopy, sigmoidoscopy, anoscopy, colonoscopy)	25% after deductible	50% after deductible
Diagnostic Lab	25% after deductible	50% after deductible
Emergency Use of the Emergency Room	$300 copay; 25% after	
Emergency Physician & Ancillary Services	25% after deductible	
Non-emergency use of the Emergency Room	Not Covered	
Mental Health & Substance Abuse Office Visits	$30 copay; 25% after	50% after deductible
Occupational & Physical Therapy (combined 40 visits/benefit period)	25% after deductible	50% after deductible
Pulmonary Therapy (20 visits/ benefit period)	25% after deductible	50% after deductible
Speech Therapy – Habilitation (20 visits/benefit period)	25% after deductible	50% after deductible
Surgery	25% after deductible	50% after deductible

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Benefit	Member Pays In-Network	Member Pays Non-Network
Inpatient Services		
Maternity/Obstetrics/Delivery	25% after deductible	50% after deductible
Mental Health & Substance Abuse	25% after deductible	50% after deductible
Physical Rehabilitation (60 days per benefit period)	25% after deductible	50% after deductible
Semi-Private Room and Board	25% after deductible	50% after deductible
Skilled Nursing Facility (90 days per benefit period)	25% after deductible	50% after deductible
Surgery	25% after deductible	50% after deductible
Additional Services		
Ambulance	25% after deductible	50% after deductible
Durable Medical Equipment and Medical Supplies	25% after deductible	50% after deductible
Home Health Services (100 visits per benefit period)	25% after deductible	50% after deductible
Hospice Services	25% after deductible	50% after deductible
Diagnostic Imaging (CT/PET Scans and MRI's)	25% after deductible	50% after deductible
Organ Transplants Unrelated Donor Search - $30,000 maximum per transplant Transportation, meals and lodging - $10,000 max per transplant	25% after deductible	50% after deductible
Private Duty Nursing (90 days per benefit period)	25% after deductible	50% after deductible
Prescription Drugs[2]		
Generic	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	
Preferred Brand	In-Network Retail: $60 copay for up to a 30-day supply In-Network Mail Order: $180 copay for up to a 90-day supply	
Non-Preferred Brand Drugs	In-Network Retail: 50% up to a $350 max per script for up to a 30-day supply In-Network Mail Order: 50% up to a $1050 max per script for up to a 90-day supply	
Specialty High-Cost Drugs	In-Network Retail & Mail Order: 50% up to a $350 max per script for up to a 30-day supply	
Pediatric Dental		
The plan design includes pediatric dental unless coverage is purchased elsewhere; if purchased elsewhere, proof of pediatric dental coverage must be supplied to Medical Mutual. If a Medical Mutual dental product is purchased, pediatric dental will be included in the dental product design.	Covered (Refer to Pediatric Dental Plan details)	

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.

Notes Continued

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.

This product is available to all Ohio residents.

Footnotes

[1] This product has an embedded accumulation applied. Embedded 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. Embedded Maximum Out-of-Pocket (MOOP): Any combination of family members may satisfy the family out-of-pocket 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.

[2]Drug benefit contains the following:

- Prescription drug coverage will be subject to a formulary.
- Generic Incentive: If the member or physician request 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.