

Benefits	Network	Non-Network
Benefit Period	January 1 st through December 31 st	
Dependent Age	Up to Age 26 Removal upon End of Month	
Older Age Child	Ages 26 - 28 Removal upon End of Month (cost of coverage at the employee's expense)	
Pre-Existing Condition Waiting Period	Not Applicable	
Blood Pint Deductible	0 pints	
Overall Annual Benefit Period Maximum	Unlimited	
3 month Deductible Carryover	Not Covered	
Benefit Period Deductible – Single/Family ¹	\$250/\$500	\$425/\$950
Coinsurance	90%	70%
Coinsurance Limit - (Excluding Deductible) – Single/Family	\$925/\$1,725	\$2,000/\$4,000
Total Medical Out-of-Pocket Maximums – (Including Deductible) -Single/Family	\$1,175/\$2,225	\$2,425/\$4,950
Physician/Office Services		
Office Visit (Illness/Injury) ²	\$15 copay, then 100%	70% after deductible
Urgent Care Office Visit ²	\$15 copay, then 100%	70% after deductible
Advanced Practicing Nurse/Office Visit ²	\$10 copay, then 100%	70% after deductible
All Immunizations – Medically Necessary	90% after deductible	70% after deductible
Administration of H1N1	100%	
Preventive Services		
Preventive Services, in accordance with state and federal law³	100%	70% after deductible
Routine Physical Exams (Age 21 and over)	100%	70% after deductible
Well Child Care Services including Exams, Well Child Care Immunizations and Laboratory Tests (To age 21)	100%	70% after deductible
Routine X-rays, Labs and Medical Tests	100%	70% after deductible
Routine Colonoscopy	100%	70% after deductible
Routine Mammogram (One per benefit period)	100%	70% after deductible
Routine Pap Test (One per benefit period)	100%	70% after deductible
Routine PSA Test	100%	70% after deductible
Routine Vision Exam (One per benefit period)	100%	70% after deductible
Routine Hearing Exam (One per benefit period)	100%	70% after deductible
Outpatient Services		
Surgical Services	90% after deductible	70% after deductible
Diagnostic Services	90% after deductible	70% after deductible
Physical Therapy & Occupational Therapy - Facility and Professional (40 visits combined per benefit period)	90% after deductible	70% after deductible
Chiropractic Therapy – Professional Only (12 visits per benefit period)	90% after deductible	70% after deductible
Speech Therapy – Facility and Professional (20 visits per benefit period)	90% after deductible	70% after deductible
Cardiac Rehabilitation	90% after deductible	70% after deductible
Emergency use of an Emergency Room ⁴	\$75 copay, then 100%	

Non-Emergency use of an Emergency Room	90% after deductible	70% after deductible
Benefits	Network	Non-Network
Inpatient Facility		
Semi-Private Room and Board	90% after deductible	70% after deductible
Maternity Services	90% after deductible	70% after deductible
Skilled Nursing Facility	90% after deductible	70% after deductible
Human Organ Transplants	90% after deductible	70% after deductible
Additional Services		
Allergy Testing	90% after deductible	70% after deductible
Allergy Treatments	90% after deductible	70% after deductible
Ambulance Services includes Air	90% after deductible	70% after deductible
Durable Medical Equipment / Medical Supplies	90% after deductible	70% after deductible
Home Healthcare	90% after deductible	70% after deductible
Hospice Services	90% after deductible	70% after deductible
Private Duty Nursing - \$5,000 per benefit period limit	90% after deductible	70% after deductible
Mental Health and 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		

Note: Services requiring a copayment are not subject to the single/family deductible.

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

Deductible and coinsurance expenses incurred for services by a network provider will not apply to the non-network deductible and coinsurance out-of-pocket limits.

Non-Contracting and Facility Other Providers will pay the same as Non-Network.

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.

¹Maximum family deductible. Member deductible is the same as single deductible.

²The office visit copay applies to the cost of the office visit only.

³Preventive 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.

⁴Copay waived if admitted. The copay applies to room charges only. All other covered charges are not subject to deductible.

December 6, 2011