

BENEFITS		1500/3000	
Benefit Period	January 1 st through December 31 st		
Dependent Age Limit	The end of the month of the 23 rd birthday		
Lifetime Maximum	\$2,500,000		
Benefit Period Deductible ¹ — Single/Family	\$1,500/\$3,000		
Network Coinsurance	80%		
Network Coinsurance Out-of-Pocket Maximum — Single/Family	\$2,000/\$4,000		
Non-Network Coinsurance	60%		
Non-Network Coinsurance Out-of-Pocket Maximum — Single/Family	\$2,500/\$5,000		
MEDICAL SERVICES	In-Network	Out-of-Network	
Medical Necessary Office Visits ²	\$15 copay per visit then 100%	\$15 copay per visit then 60%	
Urgent Care Office Visit ²	\$15 copay per visit then 100%	\$15 copay per visit then 60%	
Routine Office Visit ²	\$15 copay per visit then 100%	\$15 copay per visit then 50% ³	
Well Child Care Services (to age nine) \$500 maximum per benefit period Office Visit ² Immunizations	\$15 copay per visit then 100% 80% after deductible	\$15 copay per visit then 50% ³ 60% after deductible	
Routine Pap Smear — One per benefit period	80% after deductible	60% after deductible	
Routine Mammogram — One per benefit period up to \$85	80% after deductible	60% after deductible	
Outpatient Diagnostic Services	80% after deductible	60% after deductible	
One Routine EKG, chest X-ray, comprehensive metabolic panel, urinalysis and complete blood count per benefit period	80% after deductible	60% after deductible	
Outpatient Surgery	80% after deductible	60% after deductible	
Physical and Occupational Therapy (\$5,000 combined maximum per benefit period), Speech Therapy (\$5,000 maximum per benefit period) and Chiropractic Services (12 visits per benefit period)	80% after deductible	60% after deductible	
Inpatient Hospital/Surgical Services	80% after deductible	60% after deductible	
Emergency Use of a Hospital Emergency Room	\$100 copay, waived if admitted then 80%	\$100 copay, waived if admitted then 80%	
Non-Emergency Use of a Hospital Emergency Room	\$100 copay then 80% for room charges; all other charges 80% after deductible	\$100 copay then 60% for room charges; all other charges 60% after deductible	
Ambulance Service	\$100 copay then 80%	\$100 copay then 60%	
Private Duty Nursing — \$1,000 maximum per benefit period	80% after deductible	60% after deductible	
Home Health Care	80% after deductible	50% ³ after deductible	
Skilled Nursing — \$10,000 maximum per benefit period	80% after deductible	60% after deductible	
Hospice	80% after deductible	50% ³ after deductible	
MENTAL HEALTH AND SUBSTANCE ABUSE			
Inpatient Mental/Substance Abuse Services: (30 days per benefit period; Substance Abuse limited to one admission per benefit period and three admits per lifetime)	80% after deductible	50% ³ after deductible	
Outpatient Mental/Substance Abuse Services: (20 visits per benefit period)	50% ³ after deductible	50% ³ after deductible	
PRESCRIPTION DRUG – ORAL CONTRACEPTIVES INCLUDED			
Prescription Drug Benefit Period Deductible – ⁴ Single/Family	\$250/\$500		
Benefit Period Maximum ⁵	\$2,000		
Retail — 30 Day Supply	80% after deductible	60% after deductible	
Home Delivery — 90 Day Supply	80% after deductible	Not Covered	

OPTIONAL BENEFITS		
\$500 Professional Services Rider	100% up to \$500 per benefit period	Subject to deductible and coinsurance
Maternity Rider — Option 1 Benefits are payable after 270 days of coverage under maternity rider. Limited to \$2,000 per benefit period.	80% Not subject to deductible	60% Not subject to deductible
Maternity Rider — Option 2 Benefits are payable after 270 days of coverage under maternity rider with no dollar maximum	80% ³ after deductible	60% ³ after deductible
Prescription Drug Rider – Oral Contraceptives Included ⁶		
Retail – 30 Day Supply	\$15 Generic / \$30 Formulary / \$45 Non-Formulary	
Home Delivery – 90 Day Supply	\$30 Generic / \$60 Formulary / \$90 Non-Formulary	

Coinsurance insurance expenses incurred for services by a non-network provider will also apply to the network coinsurance out-of-pocket.

This document is not a contract of insurance. It is a partial listing of healthcare benefits. Refer to your certificate for a complete listing of healthcare benefits. Benefits are determined based on Medical Mutual of Ohio's medical and administrative policies and procedures.

No person other than an officer of Medical Mutual of Ohio 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 of Ohio's payment may not equal the percentage listed in these charts. However, the covered person's coinsurance will always be based on the lesser of the provider's billed charges or Medical Mutual of Ohio's negotiated rate with the provider.

-
- ¹ Copays do not accumulate to deductible or coinsurance limits.
 - ² Office visit copay applies to the cost of the office visit only.
 - ³ Coinsurance does not apply to out of pocket maximum. These services will not be covered at 100% once coinsurance out-of-pocket maximum is met.
 - ⁴ The Prescription Drug Benefit Period Deductible includes deductibles paid for both retail and home delivery drugs.
 - ⁵ The benefit period maximum is combined for both retail and mail order drugs.
 - ⁶ Drug benefit contains the following:
 - Rx Selections® Drug List: A list of drugs on the Rx Selections® formulary will be used.
 - 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.

Benefits listed are for new groups and renewals effective September 1, 2003