Traditional Plan Summary

Subcategory	PHG Network	Extended Network	Non-Network
Dependent Age	26		
Dependent Removal	End of Month		
Overall Benefit Period Maximum	Unlimited		
Claims Filing Limit	12 months		
How Claims are Paid			
Benefit Period	January 1st through December 31st		
Coinsurance	10%	30%	Not Covered
Benefit Period Deductible - Single	$1,500	$4,000	Not Covered
Benefit Period Deductible - Family	$3,000	$8,000	Not Covered
Type of Deductible Processing	Embedded Deductible		
Maximum Out-of-Pocket Limits - Single (the sum of any applicable deductible, coinsurance and copays)	$6,750	$6,750	Does Not Apply
Maximum Out-of-Pocket Limits - Family (the sum of any applicable deductible, coinsurance and copays)	$13,500	$13,500	Does Not Apply
Emergency Room			
Emergency - Medical/Accident - Emergency Room	$350 copay, then 100% (copay is waived if admitted)		
Emergency - Medical/Accident – Ancillaries/Physicians	100%		
Non-Emergency - Emergency Room/Physicians	Not Covered		Not Covered
Inpatient Services			
Anesthesia	10% after deductible	30% after deductible	Not Covered
Consultations	10% after deductible	30% after deductible	Not Covered
Newborn Care	10% after deductible	30% after deductible	Not Covered
Institutional Services	10% after deductible	30% after deductible	Not Covered
Maternity	10% after deductible	30% after deductible	Not Covered
Physical Medicine and Rehabilitation	10% after deductible	30% after deductible	Not Covered
Professional Services	10% after deductible	30% after deductible	Not Covered
Skilled Nursing Facility (180 days per benefit period)	10% after deductible	30% after deductible	Not Covered
Mental Health, Alcohol and Drug Abuse			

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Inpatient Alcoholism, Drug Abuse & Mental Health Services	Benefits paid based on corresponding medical benefits	Benefits paid based on corresponding medical benefits	Not Covered
Outpatient Drug Abuse, Alcoholism & Mental Health Services	Benefits paid based on corresponding medical benefits	Benefits paid based on corresponding medical benefits	Not Covered
Office Visits Illness/Injury			
Medically Necessary Office Visits/Consultations - PCP	$20 copay, then 100%	30% after deductible	Not Covered
Telemedicine (covered through Premier Virtual Care)	$35 copay, then 100%	Does Not Apply	Does Not Apply
Medically Necessary Office Visits/Consultations - Specialist	$40 copay, then 100%	30% after deductible	Not Covered
Urgent Care Provider Office Visits	$35 copay, then 100%	$50 copay, then 100%	Not Covered
Convenience Clinics	Does Not Apply	$35 copay, then 100%	Not Covered
Outpatient Services			
Allergy Testing	$40 copay, then 100%	30% after deductible	Not Covered
Allergy Treatment	$40 copay, then 100%	30% after deductible	Not Covered
Diagnostic Imaging	10% after deductible	30% after deductible	Not Covered
Diagnostic Lab/X-ray/Medical Tests	100% (Physician Office or Independent Lab); 10% after deductible (All other Places of Service)	30% after deductible	Not Covered
Education and Training (includes 3 visits for Medical Nutrition Therapy/Diabetic)	10% after deductible, unless the service is covered under Health Care Reform Preventive Benefits	30% after deductible, unless the service is covered under Health Care Reform Preventive Benefits	Not Covered
Home Health Care	10% after deductible	30% after deductible	Not Covered
All Immunizations	10% after deductible, unless the service is covered under Health Care Reform Preventive Benefits	30% after deductible, unless the service is covered under Health Care Reform Preventive Benefits	Not Covered
Maternity (Prenatal Visits are covered at no charge with in-network providers)	10% after deductible	30% after deductible	Not Covered
Surgical Services – (except for orthognathic surgery, which is not covered) - Anesthesia - Assistant Surgeon - Surgery professional - Diagnostic - Endoscopic services	100% (Physician Office); 10% after deductible (All other Places of Service)	30% after deductible	Not Covered
Surgical Services - Surgery Facility	10% after deductible	30% after deductible	Not Covered

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Outpatient Therapy			
Cardiac Rehabilitation (36 visits per benefit period)	10% after deductible	30% after deductible	Not Covered
Chemotherapy	10% after deductible	30% after deductible	Not Covered
Chiropractic (20 visits per benefit period)	50% after deductible	50% after deductible	Not Covered
Dialysis Treatment	10% after deductible	30% after deductible	Not Covered
Hyperbaric Therapy	10% after deductible	30% after deductible	Not Covered
- Occupational Therapy - Speech Therapy - Physical Therapy (60 visits per benefit period combined)	10% after deductible	30% after deductible	Not Covered
Pulmonary Therapy (24 visits per benefit period)	10% after deductible	30% after deductible	Not Covered
Radiation Therapy	10% after deductible	30% after deductible	Not Covered
Respiratory Therapy	10% after deductible	30% after deductible	Not Covered
Preventive Exams and Immunizations			
Hearing Exam (age 21 & over)	10% after deductible	30% after deductible	Not Covered
All Immunizations	10% after deductible, unless the service is covered under Health Care Reform Preventive Benefits	30% after deductible, unless the service is covered under Health Care Reform Preventive Benefits	Not Covered
Physical Exam (age 21 & over)	100%	100%	Not Covered
Vision Exam (age 21 & over)	$20 copay, then 100% (PCP); $40 copay, then 100% (Specialist)	30% after deductible	Not Covered
Bone Density Tests (Females)	100% (age 50 and over); 10% after deductible (under age 50)	100% (age 50 and over); 30% after deductible (under age 50)	Not Covered
- Lab - X-rays - Medical Tests - Endoscopic Services (includes Colonoscopies related to family history for colon cancer covered at 100%, under age 50)	10% after deductible, unless the service is covered under Health Care Reform Preventive Benefits	30% after deductible, unless the service is covered under Health Care Reform Preventive Benefits	Not Covered
Mammogram (1 per benefit period)	100%	100%	Not Covered
Pap Test (1 per benefit period)	100%	100%	Not Covered
Well Child Care (age limit 21)			
Exams	100%	100%	Not Covered
Hearing Exams	$20 copay, then 100% (PCP); $40 copay, then 100% (Specialist), unless the service is covered under Health Care Reform Preventive Benefits	30% after deductible, unless the service is covered under Health Care Reform Preventive Benefits	Not Covered

Subcategory	PHG Network	Extended Network	Non-Network
All Immunizations	10% after deductible, unless the service is covered under Health Care Reform Preventive Benefits	30% after deductible, unless the service is covered under Health Care Reform Preventive Benefits	Not Covered
Labs	10% after deductible, unless the service is covered under Health Care Reform Preventive Benefits	30% after deductible, unless the service is covered under Health Care Reform Preventive Benefits	Not Covered
Vision Exams (1 per benefit period)	$20 copay, then 100% (PCP); $40 copay, then 100% (Specialist), unless the service is covered under Health Care Reform Preventive Benefits	30% after deductible, unless the service is covered under Health Care Reform Preventive Benefits	Not Covered
Additional Services			
Abortions - Elective	Not Covered		Not Covered
Abortions - Therapeutic	10% after deductible	30% after deductible	Not Covered
Acupuncture	Not Covered		Not Covered
Ambulance	10% after deductible		
Approved Clinical Trial	Benefits paid based on services rendered		
Autism Spectrum Disorders (other than ABA) Only the following services are covered subject to limits on corresponding benefits (up to age 14): OP Occupational, Physical and Speech Therapies and OP Mental Health	Benefits paid based on corresponding medical benefits	Benefits paid based on corresponding medical benefits	Not Covered
Applied Behavior Analysis(ABA)	Not Covered		Not Covered
Blood, Blood Typing and Administration	10% after deductible	30% after deductible	Not Covered
Diabetes Disease Management (DM) Program (Materials covered under the DM program are not listed in certificate)	Limited Supplies - no cost share		
Durable Medical Equipment (orthopedic shoes and orthotics are only covered for the diagnosis of diabetes and peripheral vascular disease)	20% after deductible	30% after deductible	Not Covered
DME – Wigs ($500 per benefit period following cancer treatment or alopecia diagnosis)	20% after deductible	30% after deductible	Not Covered
Gender Transition Treatment	Benefits paid based on corresponding medical benefits	Benefits paid based on corresponding medical benefits	Not Covered
Hospice	10% after deductible	30% after deductible	Not Covered
Medical Supplies	20% after deductible	30% after deductible	Not Covered

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Non-emergency care when traveling outside the United States	Not Covered		Not Covered
Oral Accident	10% after deductible	30% after deductible	Not Covered
Organ Transplant	10% after deductible	30% after deductible	Not Covered
Organ Transplant Services (includes travel, meals, lodging and transportation) ($10,000 per lifetime)	10% after deductible	10% after deductible	Not Covered
Orthoptic Training	Not Covered		Not Covered
Private Duty Nursing	Not Covered		Not Covered
Routine Foot Care for Peripheral Vascular Disease/Diabetes	Not Covered		Not Covered
TMJ	Not Covered		Not Covered
Weight Loss Surgical Services (Bariatric Surgery) ($25,000 per lifetime)	10% after deductible (Miami Valley Hospital); Not Covered (All other Providers)	Not Covered	Not Covered
Limit (includes Hearing Aids, Hearing Aid Evaluation, Conformity Evaluation and Fitting)	$2,000 every 2 benefit periods		

Benefits will be administered by Medical Mutual of Ohio. This document is only a partial listing of benefits. This is not a contract of insurance. The contract or certificate will contain the complete listing of covered services