

Traditional Plan Summary

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

Subcategory	PHG Network	Extended Network	Non-Network
Inpatient Alcoholism, Drug	Benefits paid based on	Benefits paid based on	Not Covered
Abuse & Mental Health Services	corresponding medical	corresponding medical	
	benefits	benefits	
Outpatient Drug Abuse,	Benefits paid based on	Benefits paid based on	Not Covered
Alcoholism & Mental Health	corresponding medical	corresponding medical	
Services What are the investment	benefits	benefits	
Office Visits Illness/Injury Medically Necessary Office	\$20 copay, then 100%	30% after deductible	Not Covered
Visits/Consultations - PCP	\$20 copay, then 100%	30% after deductible	Not covered
Telemedicine (covered through	\$35 copay, then 100%	Does Not Apply	Does Not Apply
Premier Virtual Care)	755 copay, then 100%	Does Not Apply	Does Not Apply
Medically Necessary Office	\$40 copay, then 100%	30% after deductible	Not Covered
Visits/Consultations - Specialist	φ το σοραγή εποπ 200/σ		
Urgent Care Provider Office	\$35 copay, then 100%	\$50 copay, then 100%	Not Covered
Visits		, ,,,	
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	100% (Physician Office or	30% after deductible	Not Covered
Tests	Independent Lab); 10%		
	after deductible (All other		
	Places of Service)		
Education and Training (includes	10% after deductible,	30% after deductible,	Not Covered
3 visits for Medical Nutrition	unless the service is covered under Health Care	unless the service is covered under Health	
Therapy/Diabetic)	Reform Preventive Benefits	Care Reform	
	Reform Freventive Benefits	Preventive Benefits	
Home Health Care	10% after deductible	30% after deductible	Not Covered
All Immunizations	10% after deductible,	30% after deductible,	Not Covered
	unless the service is	unless the service is	
	covered under Health Care	covered under Health	
	Reform Preventive Benefits	Care Reform	
		Preventive Benefits	
Maternity (Prenatal Visits are	10% after deductible	30% after deductible	Not Covered
covered at no charge with in-			
network providers)			
Surgical Services –	100% (Physician Office);	30% after deductible	Not Covered
(except for orthognathic	10% after deductible (All		
surgery, which is not covered)	other Places of Service)		
- Anesthesia			
- Assistant Surgeon			
- Surgery professional - Diagnostic			
- Endoscopic services			
Surgical Services - Surgery	10% after deductible	30% after deductible	Not Covered
Facility		23/2 3.13/ 434401010	
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Subcategory	PHG Network	Extended Network	Non-Network
Outpatient Therapy			
Cardiac Rehabilitation (36 visits	10% after deductible	30% after deductible	Not Covered
per benefit period)			
Chemotherapy	10% after deductible	30% after deductible	Not Covered
Chiropractic (20 visits per	50% after deductible	50% after deductible	Not Covered
benefit period)			
Dialysis Treatment	10% after deductible	30% after deductible	Not Covered
Hyperbaric Therapy	10% after deductible	30% after deductible	Not Covered
- Occupational Therapy	10% after deductible	30% after deductible	Not Covered
- Speech Therapy			
- Physical Therapy (60 visits per			
benefit period combined)			
Pulmonary Therapy (24 visits	10% after deductible	30% after deductible	Not Covered
per benefit period)	10% diter deddetible	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 Immuniza	tions		•
Hearing Exam (age 21 & over)	10% after deductible	30% after deductible	Not Covered
All Immunizations	10% after deductible,	30% after deductible,	Not Covered
	unless the service is	unless the service is	
	covered under Health Care	covered under Health	
	Reform Preventive Benefits	Care Reform	
		Preventive Benefits	
Physical Exam (age 21 & over)	100%	100%	Not Covered
Vision Exam (age 21 & over)	\$20 copay, then 100%	30% after deductible	Not Covered
	(PCP); \$40 copay, then		
	100% (Specialist)	1000// 50	
Bone Density Tests (Females)	100% (age 50 and over);	100% (age 50 and	Not Covered
	10% after deductible	over); 30% after	
	(under age 50)	deductible (under age 50)	
- Lab	10% after deductible,	30% after deductible,	Not Covered
- X-rays	unless the service is	unless the service is	Not covered
- Medical Tests	covered under Health Care	covered under Health	
- Endoscopic Services (includes	Reform Preventive Benefits	Care Reform	
Colonoscopies related to family		Preventive Benefits	
history for colon cancer covered			
at 100%, under age 50)			
14 1 6	1000/	1000/	N. C.
Mammogram (1 per benefit	100%	100%	Not Covered
period) Pap Test (1 per benefit period)	100%	100%	Not Covered
Well Child Care (age limit 21)	100/0	100/0	INOL COVERED
Exams	100%	100%	Not Covered
Hearing Exams	\$20 copay, then 100%	30% after deductible,	Not Covered
	(PCP); \$40 copay, then	unless the service is	
	100% (Specialist), unless	covered under Health	
	the service is covered	Care Reform	
	under Health Care Reform	Preventive Benefits	
	Preventive Benefits		

All immunizations 10% after deductible, unless the service is covered under Health Care Reform Preventive Benefits 10% after deductible, unless the service is covered under Health Care Reform Preventive Benefits 20% after deductible, unless the service is covered under Health Care Reform Preventive Benefits 20% after deductible, unless the service is covered under Health Care Reform Preventive Benefits 2520 copay, then 100% (Specialist), unless the service is covered under Health Care Reform Preventive Benefits 2520 copay, then 100% (Specialist), unless the service is covered under Health Care Reform Preventive Benefits 2520 copay, then 100% (Specialist), unless the service is covered under Health Care Reform Preventive Benefits 2520 copay, then 100% (Specialist), unless the service is covered under Health Care Reform Preventive Benefits 2520 copay, then 100% (Specialist), unless the service is covered under Health Care Reform Preventive Benefits 2520 copay, then 100% (Specialist), unless the service is covered under Health Care Reform Preventive Benefits 2520 copay, then 100% (Specialist), unless the service is covered under Health Care Reform Preventive Benefits 2520 copay, then 100% (Specialist), unless the service is covered under Health Care Reform Preventive Benefits 2520 copay, then 100% (Specialist), unless the service is covered under Health Care Reform Preventive Benefits 2520 copay, then 100% (Specialist), unless the service is covered under Health Care Reform Preventive Benefits 2520 copay, then 100% (Specialist), unless the service is covered under Health Care Reform Preventive Benefits 2520 copay, then 100% (Specialist), unless the service is covered under Health Care Reform Preventive Benefits 2520 copay, then 100% (Specialist), unless the service is covered under Health Care Reform Preventive Benefits 2520 copay, then 100% (Specialist), unless the service is covered under Health Care Reform Preventive Benefits 2520 copay, then 100% (Specialist), unless the s	Subcategory	PHG Network	Extended Network	Non-Network
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Reform Preventive Benefits				
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covered under Health Care Reform Preventive Benefits Preventive Be	Labs		30% after deductible,	Not Covered
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100% (Specialist), unless the service is covered under Health Care Reform Preventive Benefits	Vision Exams (1 per benefit	\$20 copay, then 100%	30% after deductible,	Not Covered
the service is covered under Health Care Reform Preventive Benefits Additional Services Abortions - Elective Not Covered Not Covered Abortions - Therapeutic 10% 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 Applied Behavior Analysis(ABA) Blood, Blood Typing and Administration Diabetes Disease Management (DM) Program (Materials covered under the DM program are not listed in certificate) Durable Medical Equipment (orthopedic shoes and orthotics are only covered for the diagnosis of diabetes and peripheral vascular disease) DME — Wigs (\$500 per benefit period following cancer treatment or alopecia diagnosis) Gender Transition Treatment Benefits paid based on corresponding medical benefits Not Covered corresponding medical benefits Not Covered Andinistration Limited Supplies - no cost share Care Reform Preventive Benefits Not Covered Not Covered orresponding medical penefit period following cancer treatment or alopecia diagnosis) Benefits paid based on corresponding medical benefits Care Reform Preventive Benefits Pack and Solve and Pottocovered or Covered	period)	(PCP); \$40 copay, then	unless the service is	
Additional Services Abortions - Elective Not Covered Not Covered Not Covered Acupuncture Not Covered Not Covered Not Covered Acupuncture Not Covered		100% (Specialist), unless	covered under Health	
Additional Services Abortions - Elective Abortions - Therapeutic Acupuncture Acupuncture Ambulance Approved Clinical Trial 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 Applied Behavior Analysis(ABA) Blood, Blood Typing and Administration Diabetes Disease Management (DM) Program (Materials covered under the DM program are not listed in certificate) Durable Medical Equipment (orthopedic shoes and orthotics are only covered for the diagnosis of diabetes and peripheral vascular disease) DME — Wigs (\$500 per benefit period following cancer treatment or alopecia diagnosis) Gender Transition Treatment Benefits paid based on corresponding medical benefits Not Covered ONA Sere deductible Age Replace Benefits paid based on corresponding medical benefits Not Covered ONA Sere deductible ONA Sere d		the service is covered	Care Reform	
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Abortions - Elective		Preventive Benefits		
Abortions - Therapeutic	Additional Services			
Acupuncture	Abortions - Elective	Not Covered		Not Covered
Ambulance 10% after deductible 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 Applied Behavior Analysis(ABA) Not Covered Blood, Blood Typing and Administration Diabetes Disease Management (DM) Program (Materials covered under the DM program are not listed in certificate) Durable Medical Equipment (orthopedic shoes and orthotics are only covered for the diagnosis of diabetes and peripheral vascular disease) DME – Wigs (\$500 per benefit 20% after deductible 30% after deductible Not Covered Not Co	Abortions - Therapeutic	10% after deductible	30% after deductible	Not Covered
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Administration Diabetes Disease Management (DM) Program (Materials covered under the DM program are not listed in certificate) Durable Medical Equipment (orthopedic shoes and orthotics are only covered for the diagnosis of diabetes and peripheral vascular disease) DME – Wigs (\$500 per benefit period following cancer treatment or alopecia diagnosis) Gender Transition Treatment Benefits paid based on corresponding medical benefits Limited Supplies - no cost share Limited Supplies - no cost share 20% after deductible 30% after deductible Not Covered Not Covered Not Covered Not Covered Corresponding medical benefits	Blood, Blood Typing and	10% after deductible	30% after deductible	Not Covered
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treatment or alopecia diagnosis) Gender Transition Treatment Benefits paid based on corresponding medical benefits Benefits paid based on corresponding medical benefits				
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corresponding medical corresponding medical benefits benefits		Benefits paid based on	Benefits paid based on	Not Covered
benefits benefits		-	·	
			, ,	
	Hospice			Not Covered
Medical Supplies 20% after deductible 30% after deductible Not Covered				

Subcategory	PHG Network	Extended Network	Non-Network
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 perio	ds	



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