

Lake Erie Regional Council Standard Plans

	PPO Plan 1		PPO Plan 2		CDHP Plan (HSA Single / HSA Family)		ACA Plan	
	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network
Benefit Period	January 1st through December 31st							
Dependent Age Limit	Age 26 - Removal end of Month (Effective 7/1/16)		Age 26 - Removal end of Month (Effective 7/1/16)		Age 26 - Removal end of Month (Effective 7/1/16)		Age 26 - Removal end of Month (Effective 7/1/16)	
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
Deductible - Single / Family ¹ (with Wellness Incentive)	\$500/\$1,000	\$1,500/\$3,000	\$750/\$1,500	\$2,000/\$4,000	\$1,750/\$3,500 ⁵	\$4,000/\$8,000 ⁶	\$3,750/\$7,500	\$4,000/\$8,000
Coinsurance	90%	60%	80%	60%	90%	60%	70%	50%
Coinsurance Maximum (Excluding Deductible) - Single / Family	\$1,500/\$3,000	\$3,000/\$6,000	\$2,000/\$4,000	\$4,000/\$8,000	\$3,000/\$6,000	\$6,000/\$12,000	\$2,250/\$4,500	\$10,000/\$20,000
Maximum Out of Pocket (Ded+ Coins+Medical & Drug Copays) ³	\$6,600/\$13,200	N/A	\$6,600/\$13,200	N/A	\$6,450/\$12,900	\$10,000/\$20,000	\$6,600/\$13,200	\$14,000/\$28,000
Physician/Office Services:								
Medically Necessary Office Visit (Illness / Injury) PCP ⁴	\$25 Copay, then 100%	60% after deductible	\$30 Copay, then 100%	60% after deductible	90% after deductible	60% after deductible	\$50 Copay, then 100%	50% after deductible
Medically Necessary Office Visit (Illness / Injury) Specialist ⁴	\$40 Copay, then 100%	60% after deductible	\$45 Copay, then 100%	60% after deductible	90% after deductible	60% after deductible	\$100 Copay, then 100%	50% after deductible
Urgent Care Facility ⁴	\$40 Copay, then 100%	60% after deductible	\$45 Copay, then 100%	60% after deductible	90% after deductible	60% after deductible	\$100 Copay, then 100%	50% after deductible
Immunizations (tetanus, rabies, meningococcal polysaccharide, HPV, influenza, VSV, Hepatitis B, MMR and pneumococcal polysaccharide are covered services)	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible
Preventative / Routine Services								
Preventive Services in accordance with state and federal law	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible
Routine Physical Exam (Ages 21 and over, one per benefit period)	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible
Well Child Care Services including Exam, Routine Vision, Routine Hearing Exams, Well Child Care Immunizations and Laboratory Tests (To Age 21)	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible
Routine Mammogram (One per benefit period)	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible
Routine Pap Test (One per benefit period)	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible
Routine Exam associated with Pap Test (one per benefit period)	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible
Routine Prostate Specific Antigen (PSA)	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible
Routine Endoscopies	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible
Routine Labs, X-Rays and Medical Tests	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible	100%	50% after deductible

Lake Erie Regional Council Standard Plans

	Premium Plan		Standard Plan		Basic Plan (HSA Compatible)		ACA - Minimum Value Plan	
	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network
Outpatient Services:								
Surgical Services	90% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible	60% after deductible	100% after deductible	50% after deductible
Diagnostic Services	90% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible	60% after deductible	100% after deductible	50% after deductible
Physical, Occupational and Chiropractic Therapies (10 visits per benefit period then Med Review)	90% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible	60% after deductible	100% after deductible	50% after deductible
Speech Therapy	90% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible	60% after deductible	100% after deductible	50% after deductible
Cardiac Rehabilitation	90% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible	60% after deductible	100% after deductible	50% after deductible
Emergency Room ⁵	\$100 Copay, then 100%		\$150 Copay, then 100%		90% after deductible	60% after deductible	\$300 Copay, then 100%	
Non-Emergency use of an Emergency Room ⁶	\$200 Copay, then 90%	\$200 Copay, then 60%	\$200 Copay, then 80%	\$200 Copay, then 60%	90% after deductible	60% after deductible	\$300 Copay, then 70%	50% after deductible
Inpatient Services:								
Semi-Private Room and Board	90% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible	60% after deductible	70% after deductible	50% after deductible
Maternity	90% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible	60% after deductible	70% after deductible	50% after deductible
Skilled Nursing	90% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible	60% after deductible	70% after deductible	50% after deductible
Organ Transplants	90% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible	60% after deductible	70% after deductible	50% after deductible
Other Services								
Allergy Testing and Treatments	90% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible	60% after deductible	70% after deductible	50% after deductible
Ambulance	90% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible	60% after deductible	70% after deductible	50% after deductible
Durable Medical Equipment	90% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible	60% after deductible	70% after deductible	50% after deductible
Home Healthcare (40 visits per benefit period)	90% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible	60% after deductible	70% after deductible	50% after deductible
Hospice	90% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible	60% after deductible	70% after deductible	50% after deductible
Private Duty Nursing	90% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible	60% after deductible	70% after deductible	50% after deductible
Mental Health and Substance Abuse:								
Inpatient Mental Health and Substance Abuse Services	Benefits paid are based on corresponding medical benefits.		Benefits paid are based on corresponding medical benefits.		Benefits paid are based on corresponding medical benefits.		Benefits paid are based on corresponding medical benefits.	
Outpatient Mental Health and Substance Abuse Services	Benefits paid are based on corresponding medical benefits.		Benefits paid are based on corresponding medical benefits.		Benefits paid are based on corresponding medical benefits.		Benefits paid are based on corresponding medical benefits.	

Lake Erie Regional Council Standard Plans

	Premium Plan		Standard Plan		Basic Plan (HSA Compatible)		ACA - Minimum Value Plan	
	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network
PRESCRIPTION DRUGS								
Retail Copay (30 day supply)								
Generic	\$10.00		\$15.00		\$10 after deductible		\$10 after deductible	
Preferred Brand	\$25.00		\$30.00		\$25 after deductible		\$50 after deductible	
Non-Preferred Brand	\$50.00		\$60.00		\$50 after deductible		\$100 after deductible	
Specialty Medications	\$60.00		\$100.00		\$60 after deductible		\$200 after deductible	
Mail Order Copay (90 day supply) (Mandatory Mail)								
Generic	\$20.00		\$30.00		\$20 after deductible		\$20 after deductible	
Preferred Brand	\$50.00		\$60.00		\$50 after deductible		\$100 after deductible	
Non-Preferred Brand	\$100.00		\$120.00		\$100 after deductible		\$200 after deductible	

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

² Entire Family Deductible must be met before any benefits are provided for any member on the Basic Plan Family contract.

³ Maximum Out of Pocket amount will be subject to change based on compliance with the affordable Care Act.

⁴ The office visit copay applies to the cost of the office visit only

⁵ Copay waived if admitted. The copay applies to room charges only. All other covered charges are not subject to deductible.

⁶ Copay waived if admitted. The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance.

This benefit summary provides a brief outline of the services covered by Medical Mutual. Refer to your certificate for information regarding the administration of the plan.