County of Summit
Medical Mutual of Ohio
MedFlex Plan

Medical Mutual
MedFlex
Network

Benefit	MedFlex Network ONLY	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age	Age 26 - Removal upon end of month of 26th birthday	
Benefit Period Deductible – Single/Family	$500 / $1,000	Not Covered
Coinsurance	Plan pays 90%; Member pays 10% up to $2000/$4000	Not Covered
Maximum Out-of-Pocket (incudes Deductible, Coinsurance and all Medical and Drug Copays) Single/Family	$7,350 / $14,700	Not Covered
Physician/Office Services		
Office Visit (Illness/Injury)	$20 PCP/$40 Specialist copay	Not Covered
Urgent Care Office Visit	$40 copay	Not Covered
All Immunizations	Plan pays 100%	Not Covered
Preventive Services		
Preventive Services, in accordance with state and federal law	Plan pays 100%	Not Covered
Preventive Physical Exam (Ages 21 and over)	Plan pays 100%	Not Covered
Well Child Care Services including Exam, Routine Vision, Routine Hearing Exams, Well Child Care Immunizations (To age 21)	Plan pays 100%	Not Covered
Preventive Mammogram (One per benefit period)	Plan pays 100%	Not Covered
Preventive Pap Test (One per benefit period)	Plan pays 100%	Not Covered
Preventive Lab, X-Ray and Medical Tests	Plan pays 100%	Not Covered
Preventive Endoscopic Services	Plan pays 100%	Not Covered
Preventive Eye Exam (one per benefit period)	$40 copay then Plan pays 100%	Not Covered
Preventive Eye Refraction (one per 24 months)	Plan pays 100%	Not Covered
Outpatient Services		
Surgical Services	Plan pays 90% after deductible	Not Covered
Diagnostic Services - X-Ray, Medical Tests	Plan pays 90% after deductible	Not Covered
Diagnostic Lab	Free Standing Facility - $20 Copay; Institutional - Plan pays 90% after Deductible	Not Covered
Diagnostic and Routine Prostate Specific Antigen (PSA)	Plan pays 100%	Not Covered
Occupational Therapy (25 visits combined with Physical Therapy then subject to Med Review)	$20 PCP/$40 Specialist	Not Covered
Physical Therapy (25 visits combined with Occupational Therapy then subject to Med Review)	$20 PCP/$40 Specialist	Not Covered
Chiropractic Therapy (25 visits then subject to Med Review)	$20 PCP/$40 Specialist	Not Covered
Speech Therapy (10 visits then subject to Med Review)	$20 PCP/$40 Specialist	Not Covered
Cardiac Rehabilitation	$20 PCP/$40 Specialist	Not Covered
Emergency use of an Emergency Room	$150 copay, then 100% - copay waived if admitted	
Non-Emergency use of an Emergency Room	Not Covered	Not Covered

Benefit	Network	Non-Network
Inpatient Facility		
Semi-Private Room and Board	Plan pays 90% after deductible	Not Covered
Maternity	Plan pays 90% after deductible	Not Covered
Skilled Nursing Facility	Plan pays 90% after deductible	Not Covered
Additional Services		
Allergy Testing and Treatments	Plan pays 90% after deductible	Not Covered
Ambulance	Plan pays 90% after deductible	Not Covered
Durable Medical Equipment	Plan pays 90% after deductible	Not Covered
Home Healthcare (40 visits per benefit period)	Plan pays 90% after deductible	Not Covered
Hospice	Plan pays 90% after deductible	Not Covered
Organ Transplants ($10,000 maximum for patient transportation)	Plan pays 90% after deductible	Not Covered
Private Duty Nursing	Plan pays 90% after deductible	Not Covered
Mental Health and Substance Abuse - Federal Mental Health Parity		
Inpatient Mental Health and Substance Abuse Services	**Benefits paid based on corresponding Medical benefits**	Not Covered
Outpatient Mental Health and Substance Abuse		

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

Non-Contracting Providers and Facilities (non-network) are not covered under this plan.

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. The contract or benefit booklet will contain the complete listing of covered services. 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.

Express Scripts	Retail /Smart90 (30-day supply)	Smart90/ Mail Order (90-day supply)
Generic	$10	$20
Formulary*	$25	$50
Non-Formulary	$50	$100

**When a generic is available under the formulary and you choose the brand name drug instead, you will pay the copay plus the difference between the cost of the generic drug and the brand name drug.*

Note: All maintenance medications are required to be written for a 90-day supply and filled through Express Scripts/Mail Order Pharmacy or a Smart90 participating retail pharmacy. You will be permitted to fill two 30-day scripts of your maintenance medications at a retail pharmacy, then all subsequent refills must be written for a 90-day supply and filled through Express Scripts Mail Order Pharmacy or the Smart90 participating pharmacy.

If utilizing the Smart90 program, employees must choose a pharmacy participating in the Smart90 program. Employees must obtain a new 90-day prescription from their physician and take it to the participating pharmacy.