Summary of Benefits

Cleveland Guardians Baseball Co.

SuperMed PPO



	Network	Non-Network
	Member Pays	
Benefit Period	January 1st through December 31st	
Dependent Age Limit and Removal	26 - End of Month	
Embedded Deductible - Single / Family[1]	$600 / $1,200	$2,000 / $4,000
Embedded Coinsurance Out-of-Pocket (excludes deductible) - Single / Family	$1,250 / $2,500	$2,500 / $5,000
Maximum Out-of-Pocket - Single / Family[2]	$6,600 / $13,200	Unlimited / Unlimited
	Medical Mutual Pays[3]	
Coinsurance	80%	60%
Physician/Office Services		
Physician Office Visit	$15 copay, then 100%	60% after deductible
Specialist Office Visit	$15 copay, then 100%	60% after deductible
Urgent Care Office Visit	$15 copay, then 100%	60% after deductible
Emergency Services		
Emergency Use of an Emergency Room	$200 copay, then 80% (copay is waived if admitted)	
Emergency Services (expenses other than Emergency Room)	80%	
Non-Emergency Use of an Emergency Room	80% after deductible	80% after deductible
Routine/Preventive Services[4]		
Health Care Reform Benefits	100%	60% after deductible
Immunizations	100%	60% after deductible
Physical Exam (age 21 and over; 2 per benefit period) (combined with Family Planning Exam)	100%	60% after deductible
Mammogram (1 per benefit period)	100%	60% after deductible
Pap Test (1 per benefit period)	100%	60% after deductible
Labs	100%	60% after deductible
X-rays	100%	60% after deductible
Medical Tests	100%	60% after deductible
Routine Endoscopic Services (age 45 and over)	100%	60% after deductible
Well Child Care		
Well Child Care Exams, Immunizations and Labs to age 21	100%	60% after deductible
Hearing Exams	100%	60% after deductible
Vision Exams	100%	60% after deductible
Outpatient Services		
Allergy Testing and Treatments	80% after deductible	60% after deductible
Physical Therapy 60% after deductible	80% after deductible	(The coinsurance does not apply to the coinsurance out-of-pocket limit(s) or pay at 100% after the limit(s) is/are met.)
Occupational Therapy (The coinsurance does not apply to the coinsurance out-of-pocket limit(s) or pay at 100% after the limit(s) is/are met.)	80% after deductible	60% after deductible
Speech Therapy (CPT 92507 is covered for diagnosis codes F80.0 & F80.2)	80% after deductible	60% after deductible
Chiropractic Services (The coinsurance does not apply to the coinsurance out-of-pocket limit(s) or pay at 100% after the limit(s) is/are met.) (52 visits per benefit period)	80% after deductible	60% after deductible

Cardiac Rehabilitation	80% after deductible	60% after deductible
Surgical Services	80% after deductible	60% after deductible
Diagnostic Lab	80% after deductible	60% after deductible
Diagnostic Xrays	80% after deductible	60% after deductible
Diagnostic Medical Tests	80% after deductible	60% after deductible
Diagnostic Imaging	80% after deductible	60% after deductible
Diagnostic Endoscopic Services	80% after deductible	60% after deductible
Inpatient Services		
Hospital Services	80% after deductible	60% after deductible
Maternity	80% after deductible	60% after deductible
Skilled Nursing Facility	80% after deductible	60% after deductible
Additional Services		
Ambulance	80% after deductible	60% after deductible
Autism Spectrum Disorders	Benefits paid based on services rendered	
Durable Medical Equipment	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible
Organ and Tissue Transplants	80% after deductible	60% after deductible
Private Duty Nursing	80% after deductible	60% after deductible
Weight Loss Surgical Services	Not Covered	Not Covered
Mental Health & Substance Abuse—Federal Mental Health Parity		
Inpatient and Outpatient Mental Health and Substance Abuse Services	Benefits paid are based on corresponding medical benefits	

[1] The deductible and coinsurance out-of-pocket limit are either embedded or aggregate. When embedded, each family member must meet their own individual amounts until the total amount of expenses paid by all family members meets the overall family limit. When aggregate, the overall family limits must be met before the plan begins to pay.

[2] Network level Out-of-Pocket includes deductible and coinsurance and flat dollar copayments.

[3] If applicable, copayments are the responsibility of the member.

[4] Preventive services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, routine immunizations, and other screenings, as provided for in the Patient Protection and Affordable Care Act.

Prescription Drug Benefits	**Member Pays[3]**
Retail -	
Generic / Preferred Brand / Non-Preferred Brand	30%
Home Delivery -	
Generic / Preferred Brand / Non-Preferred Brand	30%
Specialty Drugs - Covers up to a 30 day supply. Certain specialty drugs are considered non-essential health benefits and therefore do not apply to the out-of-pocket maximum. They will also be subject to higher cost-share.	Applicable drug tier copay applies
Network / Formulary	National Plus / Basic Plus
Weight Loss Drugs	Not Covered
See certificate for Generic Incentive and Home Delivery Incentive details	

Benefits will be administered by Medical Mutual of Ohio. 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. Only an officer of Medical Mutual may agree, orally or in writing, to change the benefits listed here. The contract, certificate or benefit book will contain the complete listing of covered services. In certain instances, Medical Mutual's payment may not equal the percentage listed above. However, 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.

Plan Effective 01/01/2027