



SUPERMED ONE®



BENEFIT SUMMARIES FOR OHIO
FOR INDIVIDUALS AND FAMILIES UNDER 65



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SUPERMED ONE STANDARD PLANS WITH OFFICE VISIT COPAY

| BENEFITS | 500/1000 | 1000/2000 | 1500/3000 | 2500/5000 |
|---|---|-----------------|-----------------------------------|------------------|
| Benefit Period | January 1 through December 31 | | | |
| Dependent Age Limit | 19 Dependent; 23 Student; Removal upon End of Month | | | |
| Lifetime Maximum | \$2,500,000 | | | |
| Benefit Period Deductible – Single/Family | \$500/\$1,000 | \$1,000/\$2,000 | \$1,500/\$3,000 | \$2,500/\$5,000 |
| Non Network Benefit Period Deductible – Single/Family | \$1,000/\$2,000 | \$2,000/\$4,000 | \$3,000/\$6,000 | \$5,000/\$10,000 |
| | PPO NETWORK | | NON-PPO NETWORK | |
| Coinsurance | 80% | | 50% | |
| Coinsurance Out-of-Pocket Maximum – (Excluding Deductible) - Single/Family | \$2,000/\$4,000 | | \$4,000/\$8,000 | |
| PHYSICIAN/OFFICE SERVICES | | | | |
| Office Visit (Illness/Injury) | \$25 copay, then 100% | | 50% after deductible | |
| Urgent Care Office Visit | \$50 copay, then 100% | | \$50 copay, then 100% | |
| Immunizations | 80% after deductible | | 50% after deductible ¹ | |
| PREVENTIVE SERVICES | | | | |
| Routine Physical Exam | \$25 copay, then 100% | | 50% after deductible ¹ | |
| Well Child Care Services to age nine. Well Child Care Exams and Well Child Immunizations are limited to a \$500 maximum per benefit period | | | | |
| Well Child Exam | \$25 copay, then 100% | | 50% after deductible ¹ | |
| Well Child Immunizations and Labs | 80% after deductible | | 50% after deductible | |
| Routine Mammogram (One per benefit period) | 80% after deductible | | 50% after deductible | |
| Routine Pap Test (One per benefit period) | 80% after deductible | | 50% after deductible | |
| Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period) | 80% after deductible | | 50% after deductible ¹ | |
| OUTPATIENT SERVICES | | | | |
| Allergy Testing and Treatments | 80% after deductible | | 50% after deductible ¹ | |
| Diagnostic Services | 80% after deductible | | 50% after deductible | |
| Surgery | 80% after deductible | | 50% after deductible | |
| Physical Therapy (Institutional & Professional – 20 visits per benefit period) | \$25 copay, then 80% | | 50% after deductible | |
| Occupational Therapy (Institutional & Professional – 20 visits per benefit period) | \$25 copay, then 80% | | 50% after deductible | |
| Speech Therapy (Institutional & Professional – 20 visits per benefit period) | \$25 copay, then 80% | | 50% after deductible | |
| Chiropractic Therapy (Professional Only – 12 visits per benefit period) | \$25 copay, then 80% | | 50% after deductible | |
| Cardiac Rehabilitation (Institutional – 20 visits per benefit period) | 80% after deductible | | 50% after deductible | |
| Emergency Use of a Hospital Emergency Room | 80% after deductible | | 50% after deductible | |
| Non-Emergency Use of a Hospital Emergency Room | 80% after deductible | | 50% after deductible | |
| INPATIENT FACILITY | | | | |
| Semi-Private Room and Board | 80% after deductible | | 50% after deductible | |
| Skilled Nursing Facility (\$10,000 maximum per benefit period) | 80% after deductible | | 50% after deductible | |
| ADDITIONAL SERVICES | | | | |
| Ambulance (\$2,500 maximum per benefit period) | 80% after deductible | | 80% after deductible | |
| Durable Medical Equipment | 80% after deductible | | 50% after deductible | |
| Home Healthcare (60 visits per benefit period) | 80% after deductible | | 50% after deductible ¹ | |
| Hospice | 80% after deductible | | 50% after deductible ¹ | |
| Organ and Tissue Transplants ² | 80% after deductible | | 50% after deductible | |
| Value Vision | Discount ³ | | None | |
| MENTAL HEALTH AND SUBSTANCE ABUSE | | | | |
| Inpatient Mental/Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period and three admits per lifetime) | 80% after deductible | | 50% after deductible ¹ | |
| Outpatient Mental/Substance Abuse Visits (20 visits per benefit period) | 50% after deductible ¹ | | 50% after deductible ¹ | |
| PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED | | | | |
| Prescription Drug Benefit Period Deductible ⁴ – Single/Family | | | \$250/\$500 | |
| Benefit Period Maximum | | | \$2,000 ⁵ | |
| Retail – 30 Day Supply | 80% after deductible | | 60% after deductible | |
| Home Delivery – 90 Day Supply | 80% after deductible | | Not Covered | |
| OPTIONAL RIDERS | | | | |
| Maternity Services – Benefits payable after 270 days of coverage under maternity rider, subject to a \$1,500 maternity deductible | 80% after maternity deductible | | 50% after maternity deductible | |
| Prescription Drug Copay Rider – Oral Contraceptives included ⁶ | Generic/Formulary/Non-Formulary: | | | |
| Rider Program Copay for 30 day supply | \$15 / \$30 / \$45 | | | |
| Home Delivery Program Copay for 90 day supply | \$30 / \$60 / \$90 | | | |

Please refer to the back page for important information.

¹ Coinsurance does not apply to out-of-pocket maximums. These services will not be covered at 100% once out-of-pocket maximum is met.
² The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual Case Manager (except for corneal transplants.) Failure to contact Care Management prior to the proposed course of treatment (including the evaluation) will result in a \$5,000 penalty. There will be a \$10,000 non-network penalty for failure to use a SuperMed facility or a non designated organ transplant network healthcare professional. This penalty may be waived by the Case Manager if the proper pre-determination procedures are followed.
³ A separate Value Vision discount program highlight sheet is available. If SuperMed Vision is purchased, Value Vision will be removed from the base benefit.
⁴ The prescription drug benefit period deductible includes deductibles paid for both retail and home delivery drugs.
⁵ The benefit maximum is combined for both retail and mail order drugs.
⁶ Drug benefit contains the following:
 • Rx Selections® Drug List: A list of drugs on the Rx Selections formulary will be used
 • Generic Incentive: If the member or physician requests a brand-name drug, and a generic equivalent exists, the member pays the generic co-payment PLUS the difference between the cost of the generic drug and the brand-name drug
 • Home Delivery Incentive: When a member chooses to fill a prescription a fourth time at a retail pharmacy within 180 days, the member will pay twice the normal retail co-payment.

SUPERMED ONE STANDARD PLANS WITHOUT OFFICE COPAY

| BENEFITS | 2500/5000 | 5000/10000 | 10000/20000 |
|---|---|-----------------------------------|----------------------|
| Benefit Period | January 1 through December 31 | | |
| Dependent Age Limit | 19 Dependent; 23 Student; Removal upon End of Month | | |
| Lifetime Maximum | \$2,500,000 | | |
| Benefit Period Deductible – Single/Family | \$2,500/\$5,000 | \$5,000/\$10,000 | \$10,000/\$20,000 |
| Non Network Benefit Period Deductible – Single/Family | \$5,000/\$10,000 | \$10,000/\$20,000 | \$20,000/\$40,000 |
| | NETWORK | NON-NETWORK | |
| Coinsurance | 100% | 50% | |
| Coinsurance Out-of-Pocket Maximum – (Excluding Deductible) - Single/Family | N/A | \$4,000/\$8,000 | |
| PHYSICIAN/OFFICE SERVICES | | | |
| Office Visit (Illness/Injury) | 100% after deductible | 50% after deductible | |
| Urgent Care Office Visit | 100% after deductible | 50% after deductible | |
| Immunizations | 100% after deductible | 50% after deductible ¹ | |
| PREVENTIVE SERVICES | | | |
| Routine Physical Exam | 100% after deductible | 50% after deductible ¹ | |
| Well Child Care Services to age nine. Well Child Care Exams and Well Child Immunizations are limited to a \$500 maximum per benefit period | | | |
| Well Child Exam | 100% after deductible | 50% after deductible ¹ | |
| Well Child Immunizations and Labs | 100% after deductible | 50% after deductible | |
| Routine Mammogram (One per benefit period) | 100% after deductible | 50% after deductible | |
| Routine Pap Test (One per benefit period) | 100% after deductible | 50% after deductible | |
| Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period) | 100% after deductible | 50% after deductible | |
| OUTPATIENT SERVICES | | | |
| Allergy Testing and Treatments | 100% after deductible | 50% after deductible ¹ | |
| Diagnostic Services | 100% after deductible | 50% after deductible | |
| Surgery | 100% after deductible | 50% after deductible | |
| Physical Therapy (Institutional & Professional – 20 visits per benefit period) | 100% after deductible | 50% after deductible | |
| Occupational Therapy (Institutional & Professional – 20 visits per benefit period) | 100% after deductible | 50% after deductible | |
| Speech Therapy (Institutional & Professional – 20 visits per benefit period) | 100% after deductible | 50% after deductible | |
| Chiropractic Therapy (Professional Only – 12 visits per benefit period) | 100% after deductible | 50% after deductible | |
| Cardiac Rehabilitation (Institutional – 20 visits per benefit period) | 100% after deductible | 50% after deductible | |
| Emergency Use of a Hospital Emergency Room | 100% after deductible | 100% after deductible | |
| Non-Emergency Use of a Hospital Emergency Room | 100% after deductible | 50% after deductible | |
| INPATIENT FACILITY | | | |
| Semi-Private room and board | 100% after deductible | 50% after deductible | |
| Skilled Nursing Facility (\$10,000 maximum per benefit period) | 100% after deductible | 50% after deductible | |
| ADDITIONAL SERVICES | | | |
| Ambulance (\$2,500 maximum per benefit period) | 100% after deductible | 100% after deductible | |
| Durable Medical Equipment | 100% after deductible | 50% after deductible | |
| Home Healthcare (60 visits per benefit period) | 100% after deductible | 50% after deductible ¹ | |
| Hospice | 100% after deductible | 50% after deductible ¹ | |
| Organ and Tissue Transplants ² | 100% after deductible | 50% after deductible | |
| Value Vision | Discount ³ | None | |
| MENTAL HEALTH AND SUBSTANCE ABUSE | | | |
| Inpatient Mental/Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period and three admits per lifetime) | 100% after deductible | 50% after deductible ¹ | |
| Outpatient Mental/Substance Abuse Visits (20 visits per benefit period) | 50% after deductible ¹ | 50% after deductible ¹ | |
| PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED | | | |
| Prescription Drug Benefit Period Deductible ⁴ – Single/Family | | \$250/\$500 | |
| Benefit Period Maximum | | \$2,000 ⁵ | |
| Retail – 30 Day Supply | 80% after deductible | | 50% after deductible |
| Home Delivery – 90 Day Supply | 80% after deductible | | Not Covered |
| OPTIONAL RIDERS | | | |
| Maternity Services – Benefits payable after 270 days of coverage under maternity rider, subject to a \$1,500 maternity deductible | 100% after maternity deductible | 50% after maternity deductible | |
| Prescription Drug Copay Rider – Oral Contraceptives included ⁶ | | Generic/Formulary/Non-Formulary: | |
| Rider Program Copay for 30 day supply | | \$15 / \$30 / \$45 | |
| Home Delivery Program Copay for 90 day supply | | \$30 / \$60 / \$90 | |

Please refer to the back page for important information.

¹ Coinsurance does not apply to out-of-pocket maximums. These services will not be covered at 100% once out-of-pocket maximum is met.

² The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual Case Manager (except for corneal transplants.) Failure to contact Care Management prior to the proposed course of treatment (including the evaluation) will result in a \$5,000 penalty. There will be a \$10,000 non-network penalty for failure to use a SuperMed facility or a non designated organ transplant network healthcare professional. This penalty may be waived by the Case Manager if the proper pre-determination procedures are followed.

³ A separate Value Vision discount program highlight sheet is available. If SuperMed Vision is purchased, Value Vision will be removed from the base benefit.

⁴ The prescription drug benefit period deductible includes deductibles paid for both retail and home delivery drugs.

⁵ The benefit maximum is combined for both retail and mail order drugs.

⁶ Drug benefit contains the following:

- Rx Selections[®] Drug List: A list of drugs on the Rx Selections formulary will be used
- Generic Incentive: If the member or physician requests a brand-name drug, and a generic equivalent exists, the member pays the generic co-payment PLUS the difference between the cost of the generic drug and the brand-name drug
- Home Delivery Incentive: When a member chooses to fill a prescription a fourth time at a retail pharmacy within 180 days, the member will pay twice the normal retail co-payment.

SUPERMED ONE VALUE PLANS

| BENEFITS | 500/1000 | 1000/2000 | 1500/3000 |
|---|---|--|------------------|
| Benefit Period | January 1 through December 31 | | |
| Dependent Age Limit | 19 Dependent; 23 Student; Removal upon End of Month | | |
| Lifetime Maximum | \$2,000,000 | | |
| Benefit Period Deductible – Single/Family | \$500/\$1,000 | \$1,000/\$2,000 | \$1,500/\$3,000 |
| Non Network Benefit Period Deductible – Single/Family | \$1,500/\$3,000 | \$2,000/\$4,000 | \$2,500/\$5,000 |
| Coinsurance Out-of-Pocket Maximum – Single/Family | \$3,500/\$7,000 | \$4,000/\$8,000 | \$4,500/\$9,000 |
| Non Network Coinsurance Out-of-Pocket Maximum – Single/Family | \$7,500/\$15,000 | \$8,000/\$16,000 | \$8,500/\$17,000 |
| | NETWORK | NON-NETWORK | |
| Coinsurance | 70% | 50% | |
| PHYSICIAN/OFFICE SERVICES | | | |
| Office Visit (Illness/Injury) | 70% after deductible | 50% after deductible | |
| Urgent Care Office Visit ¹ | 70% after deductible | 50% after deductible | |
| Immunizations | 70% after deductible | 50% after deductible ¹ | |
| PREVENTIVE SERVICES | | | |
| Routine Physical Exam | | Not Covered | |
| Well Child Care Services to age nine. Well Child Care Exams and Well Child Immunizations are limited to a \$500 per child to age 1; thereafter, \$150 per child from birth to age 9 | 70% after deductible | 50% after deductible | |
| Routine Pap Test (One per benefit period) | 70% after deductible | 50% after deductible | |
| Routine Mammogram (One per benefit period) | 70% after deductible | 50% after deductible | |
| Routine EKG, Chest X-ray, Comprehensive Metabolic panel, Urinalysis and complete blood count | | Not Covered | |
| OUTPATIENT SERVICES | | | |
| Allergy Testing and Treatments | 70% after deductible | 50% after deductible ¹ | |
| Diagnostic Services | 70% after deductible | 50% after deductible | |
| Surgery | 70% after deductible | 50% after deductible | |
| Physical Therapy (Institutional & Professional – 10 visits per benefit period) | 70% after deductible | 50% after deductible | |
| Occupational Therapy (Institutional & Professional – 10 visits per benefit period) | 70% after deductible | 50% after deductible | |
| Speech Therapy (Institutional & Professional – 10 visits per benefit period) | 70% after deductible | 50% after deductible | |
| Chiropractic Therapy (Professional Only – 6 visits per benefit period) | 70% after deductible | 50% after deductible | |
| Emergency Use of a Hospital Emergency Room | | 70% after deductible | |
| Non-Emergency Use of a Hospital Emergency Room | | Not Covered | |
| INPATIENT FACILITY | | | |
| Semi-Private Room and Board | 70% after deductible | 50% after deductible | |
| Skilled Nursing Facility (\$10,000 maximum per benefit period) | 70% after deductible | 50% after deductible | |
| ADDITIONAL SERVICES | | | |
| Ambulance Services (\$2,500 maximum per benefit period) | 70% after deductible | 50% after deductible | |
| Durable Medical Equipment | 50% after deductible | 50% after deductible | |
| Home Healthcare (60 visits per benefit period) | 70% after deductible | 50% after deductible ¹ | |
| Hospice | 70% after deductible | 50% after deductible ¹ | |
| Organ and Tissue Transplants ² | 70% after deductible | 50% after deductible | |
| Value Vision | Discount ³ | None | |
| MENTAL HEALTH AND SUBSTANCE ABUSE | | | |
| Inpatient Mental/Substance Abuse Services (10 days per benefit period; Inpatient and Outpatient Substance Abuse Limited to \$550 per benefit period) ⁴ | 70% after deductible | 50% after deductible ¹ | |
| Outpatient Mental/Substance Abuse Services (10 days per benefit period; Inpatient and Outpatient Substance Abuse Limited to \$550 per benefit period) ⁴ | 50% after deductible ¹ | 50% ² after deductible ¹ | |
| PRESCRIPTION DRUG | | | |
| Benefit Period Maximum | | \$500 | |
| Retail – 30 Day Supply | | \$15 Copay – Generic drugs only ⁴ | |
| Home Delivery – 90 Day Supply | | Not Covered | |

Please refer to the back page for important information.

¹ Coinsurance does not apply to out-of-pocket maximums. These services will not be covered at 100% once out-of-pocket maximum is met.

² The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual Case Manager (except for corneal transplants.) Failure to contact Care Management prior to the proposed course of treatment (including the evaluation) will result in a \$5,000 penalty. There will be a \$10,000 non-network penalty for failure to use a SuperMed facility or a non designated organ transplant network healthcare professional. This penalty may be waived by the Case Manager if the proper pre-determination procedures are followed.

³ A separate Value Vision discount program highlight sheet is available. If SuperMed Vision is purchased, Value Vision will be removed from the base benefit.

⁴ The prescription drug benefit does not cover brand-name prescriptions under any circumstance. This applies even if a brand name drug is medically necessary and a generic substitute is not available. This also applies even when your doctor writes "dispense as written" on your prescription.

SUPERMED ONE HSA-COMPATIBLE PLANS

| BENEFITS | | 1200/2400 | |
|---|---|-----------------------------------|--|
| Benefit Period | January 1 through December 31 | | |
| Dependent Age Limit | 19 Dependent, 23 Student; Removal upon End of Month | | |
| Lifetime Maximum | \$2,500,000 | | |
| Network Benefit Period Deductible — Single/Family | \$1,200/\$2,400 ¹ | | |
| Non-Network Benefit Period Deductible — Single/Family | \$2,400/\$4,800 ¹ | | |
| | NETWORK | NON-NETWORK | |
| Network Coinsurance — Single/Family | 80% | 50% | |
| Network Coinsurance Out-of-Pocket Maximum – Single/Family | \$2,000/\$4,000 | \$4,000/\$8,000 | |
| PHYSICIAN/OFFICE SERVICES | | | |
| Office Visit (Illness/Injury) | 80% after deductible | 50% after deductible | |
| Urgent Care Office Visit | 80% after deductible | 50% after deductible | |
| Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services.) | 80% after deductible | 50% after deductible | |
| PREVENTIVE SERVICES | | | |
| Routine Physical Exam | 80% after deductible | 50% after deductible | |
| Well Child Care Services to age nine. Well Child Exams and Well Child Immunizations are limited to a \$500 maximum per benefit period. | | | |
| Office Visit & Immunizations | 80% after deductible | 50% after deductible | |
| Routine Pap Test (One per benefit period) | 80% after deductible | 50% after deductible | |
| Routine Mammogram (One per benefit period) | 80% after deductible | 50% after deductible | |
| Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period.) | 80% after deductible | 50% after deductible | |
| OUTPATIENT SERVICES | | | |
| Allergy Testing and Treatments | 80% after deductible | 50% after deductible | |
| Diagnostic Services | 80% after deductible | 50% after deductible | |
| Surgery | 80% after deductible | 50% after deductible | |
| Physical Therapy (Institutional and Professional – 20 visits per benefit period) | 80% after deductible | 50% after deductible | |
| Occupational Therapy (Institutional and Professional – 20 visits per benefit period) | 80% after deductible | 50% after deductible | |
| Speech Therapy (Institutional and Professional – 20 visits per benefit period) | 80% after deductible | 50% after deductible | |
| Chiropractic Therapy (Professional Only – 12 visits per benefit period) | 80% after deductible | 50% after deductible | |
| Cardiac Rehabilitation (Institutional Only – 20 visits per benefit period) | 80% after deductible | 50% after deductible | |
| Emergency Use of a Hospital Emergency Room | 80% after deductible | 80% after deductible | |
| Non-Emergency Use of a Hospital Emergency Room | 80% after deductible | 50% after deductible | |
| INPATIENT FACILITY | | | |
| Semi-Private Room and Board | 80% after deductible | 50% after deductible | |
| Skilled Nursing Facility (\$10,000 maximum per benefit period) | 80% after deductible | 50% after deductible | |
| ADDITIONAL SERVICES | | | |
| Ambulance (\$2,500 maximum per benefit period) | 80% after deductible | 50% after deductible | |
| Durable Medical Equipment | 80% after deductible | 50% after deductible | |
| Home Health Care (60 visits per benefit period) | 80% after deductible | 50% after deductible | |
| Hospice | 80% after deductible | 50% after deductible | |
| Organ and Tissue Transplants ² | 80% after deductible | 50% after deductible | |
| Value Vision | Discount ³ | None | |
| MENTAL HEALTH AND SUBSTANCE ABUSE | | | |
| Inpatient Mental/Substance Abuse Services (30 days per benefit period; substance abuse limited to one admission per benefit period and three admits per lifetime) | 80% after deductible | 50% ⁴ after deductible | |
| Outpatient Mental/Substance Abuse Services (20 visits per benefit period) | 50% after deductible | 50% ⁴ after deductible | |
| PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED | | | |
| Retail — 90 Day Supply | 80% after deductible | 50% after deductible | |
| Home Delivery — 90 Day Supply | 80% after deductible | Not Covered | |

¹ Maximum family deductible. Family deductible must be met before benefits are provided on a family contract.

² The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual case manager (except for corneal transplants). Failure to contact Care Management prior to the proposed course of treatment (including the evaluation) will result in a \$5,000 penalty. There will be a \$10,000 non-network penalty for failure to use a SuperMed facility or a non designated organ transplant network healthcare professional. This penalty may be waived by the Case Manager if the proper pre-determination procedures are followed.

³ A separate Value Vision discount program highlight sheet is available. If SuperMed Vision is purchased, Value Vision will be removed from the base benefit.

⁴ Coinsurance does not apply to out of pocket maximums. These services will not be covered at 100% once out-of-pocket maximum is met.

SUPERMED ONE HSA-COMPATIBLE PLANS

| BENEFITS | 2500/5000 | 3000/6000 | 5000/10000 |
|---|---|-----------------------------------|-------------------|
| Benefit Period | January 1 through December 31 | | |
| Dependent Age Limit | 19 Dependent, 23 Student; Removal upon End of Month | | |
| Lifetime Maximum | \$2,500,000 | | |
| Network Benefit Period Deductible — Single/Family | \$2,500/\$5,000 | \$3,000/\$6,000 | \$5,000/\$10,000 |
| Non-Network Benefit Period Deductible — Single/Family | \$5,000/\$10,000 | \$6,000/\$12,000 | \$10,000/\$20,000 |
| | NETWORK | NON-NETWORK | |
| Network Coinsurance — Single/Family | 100% | 50% | |
| Network Coinsurance Out-of-Pocket Maximum – Single/Family | N/A | \$4,000/\$8,000 | |
| PHYSICIAN/OFFICE SERVICES | | | |
| Office Visit (Illness/Injury) | 100% after deductible | 50% after deductible | |
| Urgent Care Office Visit | 100% after deductible | 50% after deductible | |
| Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services.) | 100% after deductible | 50% after deductible | |
| PREVENTIVE SERVICES | | | |
| Routine Physical Exam | 100% after deductible | 50% after deductible | |
| Well Child Care Services to age nine. Well Child Exams and Well Child Immunizations are limited to a \$500 maximum per benefit period. | | | |
| Office Visit & Immunizations | 100% after deductible | 50% after deductible | |
| Routine Pap Test (One per benefit period) | 100% after deductible | 50% after deductible | |
| Routine Mammogram (One per benefit period) | 100% after deductible | 50% after deductible | |
| Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period.) | 100% after deductible | 50% after deductible | |
| OUTPATIENT SERVICES | | | |
| Allergy Testing and Treatments | 100% after deductible | 50% after deductible | |
| Diagnostic Services | 100% after deductible | 50% after deductible | |
| Surgery | 100% after deductible | 50% after deductible | |
| Physical Therapy (Institutional and Professional – 20 visits per benefit period) | 100% after deductible | 50% after deductible | |
| Occupational Therapy (Institutional and Professional – 20 visits per benefit period) | 100% after deductible | 50% after deductible | |
| Speech Therapy (Institutional and Professional – 20 visits per benefit period) | 100% after deductible | 50% after deductible | |
| Chiropractic Therapy (Professional Only – 12 visits per benefit period) | 100% after deductible | 50% after deductible | |
| Cardiac Rehabilitation (Institutional Only – 20 visits per benefit period) | 100% after deductible | 50% after deductible | |
| Emergency Use of a Hospital Emergency Room | 100% after deductible | 100% after deductible | |
| Non-Emergency Use of a Hospital Emergency Room | 100% after deductible | 50% after deductible | |
| INPATIENT FACILITY | | | |
| Semi-Private Room and Board | 100% after deductible | 50% after deductible | |
| Skilled Nursing Facility (\$10,000 maximum per benefit period) | 100% after deductible | 50% after deductible | |
| ADDITIONAL SERVICES | | | |
| Ambulance (\$2,500 maximum per benefit period) | 100% after deductible | 50% after deductible | |
| Durable Medical Equipment | 100% after deductible | 50% after deductible | |
| Home Health Care (60 visits per benefit period) | 100% after deductible | 50% after deductible | |
| Hospice | 100% after deductible | 50% after deductible | |
| Organ and Tissue Transplants ¹ | 100% after deductible | 50% after deductible | |
| Value Vision | Discount ² | None | |
| MENTAL HEALTH AND SUBSTANCE ABUSE | | | |
| Inpatient Mental/Substance Abuse Services (30 days per benefit period; substance abuse limited to one admission per benefit period and three admits per lifetime) | 100% after deductible | 50% ³ after deductible | |
| Outpatient Mental/Substance Abuse Services (20 visits per benefit period) | 50% after deductible | 50% ³ after deductible | |
| PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED | | | |
| Retail — 90 Day Supply | 100% after deductible | 50% after deductible | |
| Home Delivery — 90 Day Supply | 100% after deductible | Not Covered | |

¹ The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual case manager (except for corneal transplants). Failure to contact Care Management prior to the proposed course of treatment (including the evaluation) will result in a \$5,000 penalty. There will be a \$10,000 non-network penalty for failure to use a SuperMed facility or a non designated organ transplant network healthcare professional. This penalty may be waived by the Case Manager if the proper pre-determination procedures are followed.

² A separate Value Vision discount program highlight sheet is available. If SuperMed Vision is purchased, Value Vision will be removed from the base benefit.

³ Coinsurance does not apply to out of pocket maximums. These services will not be covered at 100% once out-of-pocket maximum is met.

SUPERMED ONE WELLNESS HSA-COMPATIBLE PLANS

| BENEFITS | 2500/5000 | 3000/6000 | 5000/10000 |
|---|---|------------------|-----------------------------------|
| Benefit Period | January 1 through December 31 | | |
| Dependent Age Limit | 19 Dependent, 23 Student; Removal upon End of Month | | |
| Lifetime Maximum | \$2,500,000 | | |
| Network Benefit Period Deductible — Single/Family | \$2,500/\$5,000 | \$3,000/\$6,000 | \$5,000/\$10,000 |
| Non-Network Benefit Period Deductible — Single/Family | \$5,000/\$10,000 | \$6,000/\$12,000 | \$10,000/\$20,000 |
| | NETWORK | NON-NETWORK | |
| Network Coinsurance — Single/Family | 100% | 50% | |
| Network Coinsurance Out-of-Pocket Maximum – Single/Family | N/A | \$4,000/\$8,000 | |
| PHYSICIAN/OFFICE SERVICES | | | |
| Office Visit (Illness/Injury) | 100% after deductible | | 50% after deductible |
| Urgent Care Office Visit | 100% after deductible | | 50% after deductible |
| Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services.) | 100% after deductible | | 50% after deductible |
| PREVENTIVE SERVICES | | | |
| Routine Physical Exam | 100% no deductible | | 50% after deductible |
| Well Child Care Services to age nine. Well Child Exams and Well Child Immunizations are limited to a \$500 maximum per benefit period. | | | |
| Office Visit & Immunizations | 100% no deductible | | 50% after deductible |
| Routine Pap Test (One per benefit period) | 100% no deductible | | 50% after deductible |
| Routine Mammogram (One per benefit period) | 100% no deductible | | 50% after deductible |
| Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period.) | 100% no deductible | | 50% after deductible |
| Routine PSA, cholesterol, colon cancer screening tests, bone density tests, endoscopic services. | 100% no deductible | | 50% after deductible |
| OUTPATIENT SERVICES | | | |
| Allergy Testing and Treatments | 100% after deductible | | 50% after deductible |
| Diagnostic Services | 100% after deductible | | 50% after deductible |
| Surgery | 100% after deductible | | 50% after deductible |
| Physical Therapy (Institutional and Professional – 20 visits per benefit period) | 100% after deductible | | 50% after deductible |
| Occupational Therapy (Institutional and Professional – 20 visits per benefit period) | 100% after deductible | | 50% after deductible |
| Speech Therapy (Institutional and Professional – 20 visits per benefit period) | 100% after deductible | | 50% after deductible |
| Chiropractic Therapy (Professional Only – 12 visits per benefit period) | 100% after deductible | | 50% after deductible |
| Cardiac Rehabilitation (Institutional Only – 20 visits per benefit period) | 100% after deductible | | 100% after deductible |
| Emergency Use of a Hospital Emergency Room | 100% after deductible | | 50% after deductible |
| Non-Emergency Use of a Hospital Emergency Room | 100% after deductible | | 50% after deductible |
| INPATIENT FACILITY | | | |
| Semi-Private Room and Board | 100% after deductible | | 50% after deductible |
| Skilled Nursing Facility (\$10,000 maximum per benefit period) | 100% after deductible | | 50% after deductible |
| ADDITIONAL SERVICES | | | |
| Ambulance (\$2,500 maximum per benefit period) | 100% after deductible | | 50% after deductible |
| Durable Medical Equipment | 100% after deductible | | 50% after deductible |
| Home Health Care (60 visits per benefit period) | 100% after deductible | | 50% after deductible |
| Hospice | 100% after deductible | | 50% after deductible |
| Organ and Tissue Transplants ¹ | 100% after deductible | | 50% after deductible |
| Value Vision | Discount ² | | None |
| MENTAL HEALTH AND SUBSTANCE ABUSE | | | |
| Inpatient Mental/Substance Abuse Services (30 days per benefit period; substance abuse limited to one admission per benefit period and three admits per lifetime) | 100% after deductible | | 50% ³ after deductible |
| Outpatient Mental/Substance Abuse Services (20 visits per benefit period) | 50% after deductible | | 50% ³ after deductible |
| PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED | | | |
| Retail — 90 Day Supply | 100% after deductible | | 50% after deductible |
| Home Delivery — 90 Day Supply | 100% after deductible | | Not Covered |

¹ The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual case manager (except for corneal transplants). Failure to contact Care Management prior to the proposed course of treatment (including the evaluation) will result in a \$5,000 penalty. There will be a \$10,000 non-network penalty for failure to use a SuperMed facility or a non designated organ transplant network healthcare professional. This penalty may be waived by the Case Manager if the proper pre-determination procedures are followed.

² A separate Value Vision discount program highlight sheet is available. If SuperMed Vision is purchased, Value Vision will be removed from the base benefit.

³ Coinsurance does not apply to out of pocket maximums. These services will not be covered at 100% once out-of-pocket maximum is met.

SUPERMED ONE WELLNESS HSA-COMPATIBLE PLANS

| BENEFITS | | 1200/2400 | |
|---|---|-----------------------------------|--|
| Benefit Period | January 1 through December 31 | | |
| Dependent Age Limit | 19 Dependent, 23 Student; Removal upon End of Month | | |
| Lifetime Maximum | \$2,500,000 | | |
| Network Benefit Period Deductible — Single/Family | \$1,200/\$2,400 ¹ | | |
| Non-Network Benefit Period Deductible — Single/Family | \$2,400/\$4,800 ¹ | | |
| | NETWORK | NON-NETWORK | |
| Network Coinsurance — Single/Family | 80% | 50% | |
| Network Coinsurance Out-of-Pocket Maximum – Single/Family | \$2,000/\$4,000 | \$4,000/\$8,000 | |
| PHYSICIAN/OFFICE SERVICES | | | |
| Office Visit (Illness/Injury) | 80% after deductible | 50% after deductible | |
| Urgent Care Office Visit | 80% after deductible | 50% after deductible | |
| Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services.) | 80% after deductible | 50% after deductible | |
| PREVENTIVE SERVICES | | | |
| Routine Physical Exam | 100% no deductible | 50% after deductible | |
| Well Child Care Services to age nine. Well Child Exams and Well Child Immunizations are limited to a \$500 maximum per benefit period. | | | |
| Office Visit & Immunizations | 100% no deductible | 50% after deductible | |
| Routine Pap Test (One per benefit period) | 100% no deductible | 50% after deductible | |
| Routine Mammogram (One per benefit period) | 100% no deductible | 50% after deductible | |
| Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period.) | 100% no deductible | 50% after deductible | |
| Routine PSA, cholesterol, colon cancer screening tests, bone density tests, endoscopic services. | 100% no deductible | 50% after deductible | |
| OUTPATIENT SERVICES | | | |
| Allergy Testing and Treatments | 80% after deductible | 50% after deductible | |
| Diagnostic Services | 80% after deductible | 50% after deductible | |
| Surgery | 80% after deductible | 50% after deductible | |
| Physical Therapy (Institutional and Professional – 20 visits per benefit period) | 80% after deductible | 50% after deductible | |
| Occupational Therapy (Institutional and Professional – 20 visits per benefit period) | 80% after deductible | 50% after deductible | |
| Speech Therapy (Institutional and Professional – 20 visits per benefit period) | 80% after deductible | 50% after deductible | |
| Chiropractic Therapy (Professional Only – 12 visits per benefit period) | 80% after deductible | 50% after deductible | |
| Cardiac Rehabilitation (Institutional Only – 20 visits per benefit period) | 80% after deductible | 50% after deductible | |
| Emergency Use of a Hospital Emergency Room | 80% after deductible | 80% after deductible | |
| Non-Emergency Use of a Hospital Emergency Room | 80% after deductible | 50% after deductible | |
| INPATIENT FACILITY | | | |
| Semi-Private Room and Board | 80% after deductible | 50% after deductible | |
| Skilled Nursing Facility (\$10,000 maximum per benefit period) | 80% after deductible | 50% after deductible | |
| ADDITIONAL SERVICES | | | |
| Ambulance (\$2,500 maximum per benefit period) | 80% after deductible | 50% after deductible | |
| Durable Medical Equipment | 80% after deductible | 50% after deductible | |
| Home Health Care (60 visits per benefit period) | 80% after deductible | 50% after deductible | |
| Hospice | 80% after deductible | 50% after deductible | |
| Organ and Tissue Transplants ² | 80% after deductible | 50% after deductible | |
| Value Vision | Discount ³ | None | |
| MENTAL HEALTH AND SUBSTANCE ABUSE | | | |
| Inpatient Mental/Substance Abuse Services (30 days per benefit period; substance abuse limited to one admission per benefit period and three admits per lifetime) | 80% after deductible | 50% ⁴ after deductible | |
| Outpatient Mental/Substance Abuse Services (20 visits per benefit period) | 50% after deductible | 50% ⁴ after deductible | |
| PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED | | | |
| Retail — 90 Day Supply | 80% after deductible | 50% after deductible | |
| Home Delivery — 90 Day Supply | 80% after deductible | Not Covered | |

¹ Maximum family deductible. Family deductible must be met before benefits are provided on a family contract.

² The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual case manager (except for corneal transplants). Failure to contact Care Management prior to the proposed course of treatment (including the evaluation) will result in a \$5,000 penalty. There will be a \$10,000 non-network penalty for failure to use a SuperMed facility or a non designated organ transplant network healthcare professional. This penalty may be waived by the Case Manager if the proper pre-determination procedures are followed.

³ A separate Value Vision discount program highlight sheet is available. If SuperMed Vision is purchased, Value Vision will be removed from the base benefit.

⁴ Coinsurance does not apply to out of pocket maximums. These services will not be covered at 100% once out-of-pocket maximum is met.

SUPERMED ONE VISION BENEFITS

| BENEFITS | NETWORK | NON-NETWORK ¹ |
|--|--|--------------------------|
| Dependent Age Limit | 19 Dependent, 23 Student; Removal upon end of month | |
| PROFESSIONAL SERVICES (ONE EVERY 12 MONTHS) | | |
| Spectacle exam | \$15 copayment | \$15 maximum |
| Contact lens exam | \$15 copayment + any amount over spectacle exam | \$15 maximum |
| MATERIALS | | |
| Frame (One every 12 months) | \$0 copayment (Up to \$100) 20% off amount (Over \$100) | \$30 maximum |
| Lenses (Uncoated plastic. One pair every 12 months) | | |
| Single Vision | \$15 copayment | \$10 maximum |
| Bifocal | \$15 copayment | \$20 maximum |
| Trifocal | \$15 copayment | \$30 maximum |
| Lenticular | \$15 copayment | \$40 maximum |
| Contact lenses (instead of lenses and frames one pair per calendar year) | | |
| Cosmetic | \$15 copayment (Up to \$100) | \$40 maximum |
| Medically necessary | \$15 copayment (Up to \$200) | \$75 maximum |
| Disposable | \$15 copayment (Up to \$100) | \$40 maximum |

LISTED BELOW ARE ADDITIONAL WAYS TO SAVE ON LENS OPTIONS AND CONTACT LENSES.

If EyeMed Vision Care provider is used, members are entitled to a discount in addition to the lens copayments listed above. The discount applies to items whether or not they are covered as part of a vision plan. The available discounted lens options are listed below.

| Lens Options | Discounted Price (in addition to the \$15 lens copayment) |
|-------------------------------|---|
| Anti-reflective coating | \$45 |
| Glass | 20% off retail price |
| Photochromic | 20% off retail price |
| Polycarbonate | \$40 |
| Progressive (no-line bifocal) | \$65 |
| Scratch-resistant coating | \$15 |
| Solid tint or Gradient tint | \$15 |
| Ultraviolet coating | \$15 |

Contact Lenses

1. Visit a participating EyeMed Vision Care location and save 15% on non-disposable or medically necessary contact lenses.
2. Use the mail-order Vision One Contact Lens Replacement Program and apply discounts when ordering contacts by mail.

This document is only a partial listing of benefits. This is not a contract of insurance. No person other than an officer of Medical Mutual may agree, verbally or in writing, to change the benefits listed here. The contract or certificate will contain the complete listing of covered services.

NOTES:

The discount schedule for lens options and contact lenses listed above is subject to change by EyeMed Vision Care.

¹ The non-network maximum is the amount a member receives for covered vision services received from a non-network healthcare professional.



SUPERDENTAL[®] BENEFITS

| BENEFITS | NETWORK | NON-NETWORK |
|--|---|----------------------|
| Benefit Period | January 1 through December 31 | |
| Dependent Age Limit | 19 Dependent, 23 Student; Removal upon end of month | |
| Annual Maximum (per member) | \$1,000 per benefit period | |
| Benefit Period Deductible | \$50 per individual | \$100 per individual |
| PREVENTIVE SERVICES | | |
| Oral Exams – 2 per benefit period | 100% | 80% |
| Bite Wing X-rays – 2 per benefit period | 100% | 80% |
| Prophylaxis (cleaning) – 2 per benefit period | 100% | 80% |
| Fluoride Treatment – 1 treatment per benefit period, limited to age 19 | 100% | 80% |
| Space Maintainers- limited to age 19 | 100% | 80% |
| Emergency Palliative Treatment – includes emergency oral exam | 100% | 80% |
| ESSENTIAL SERVICES | | |
| Fillings | 80% after deductible | 60% after deductible |

BENEFIT EXCLUSIONS AND LIMITATIONS

SuperMed One does not provide benefits for services, supplies or charges for the following:

- Diagnostic X-Rays
- Minor Restorative Services
- Endodontics/Pulp Services
- Apicoectomy
- Periodontal Services
- Repairs, Relines & Adjustments of Prosthetics
- Simple Extractions
- Impactions
- Alveoplasty
- Minor Oral Surgery Services
- General Anesthesia
- Gold Foil Restoration
- Inlays, Onlays
- Crowns
- Bridgework (Pontics & Abutments)
- Partial and Complete Dentures
- Orthodontic Diagnostic Services
- Minor Treatment for Tooth Guidance
- Minor Treatment for Harmful Habits
- Interceptive Orthodontic Treatment
- Comprehensive Orthodontic Treatment

To locate a DenteMax dentist, you can contact Medical Mutual at 866/DENTAL1 (866/336-8251); visit the Medical Mutual Web site at MedMutual.com; contact DenteMax at 800/752-1547; or visit the DenteMax Web site at DenteMax.com.

NOTE:

Benefit will be determined based on Medical Mutual of Ohio's medical and administrative policies and procedures. This document is only a partial listing of dental benefits. This is not a contract of insurance. Your certificate of insurance provides a complete listing of covered services.

SUPERMED ONE LIFE INSURANCE BENEFIT

BENEFITS

Upon enrollment in SuperMed One, you are guaranteed life coverage valued at \$50,000 – no medical information is required.

You can purchase life insurance in increments of \$10,000, not to exceed \$50,000.

Spouse coverage is available in increments of \$10,000, not to exceed \$50,000. This coverage is only available when you elect and are approved for coverage for yourself.

Dependent coverage is available for children age one year and above in the amount of \$10,000. This coverage is only available when you elect and are approved for coverage for yourself.

BENEFIT LIMITATIONS

You must enroll in life insurance within 31 days of receipt of your SuperMed One contract.

The initial rates are guaranteed for five years. A 10-year age band would then apply.

Coverage terminates when you reach age 65.

NOTE:

Benefits will be determined based on Consumers Life Insurance Company's administrative policies and procedures. 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 benefits. Consumers Life Insurance Company is a subsidiary of Medical Mutual of Ohio.

BENEFIT EXCLUSIONS AND LIMITATIONS

SuperMed One coverage is not provided for services and supplies:

- Incurred before the policy effective date.
- Incurred after the policy termination date.
- For experimental or investigation of drugs, devices, medical treatments or procedures.
- That are not medically necessary.
- To the extent governmental units or their agencies provide benefits.
- For a condition that occurs as a result of any act of war.
- Received from a member of your immediate family.
- For which payment was made or would have been made under Medicare Parts A or B if benefits were claimed.
- Received in a military facility for a military service-related condition.
- For surgery and other services primarily to improve appearance or to treat a mental or emotional condition through a change in body form.
- For treatment of a condition related to an autistic disease of childhood, learning disabilities, hyperkinetic syndromes, behavioral problems or mental retardation, except as specified.
- For arch supports and other foot care or foot support devices used only to improve comfort or appearance which include but are not limited to, care of flatfeet, subluxations, corns, bunions, calluses and toenails.
- For treatment, by methods such as prescription drugs, dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss or for weight loss through surgery. This includes complications resulting from weight loss surgery or such other methods as may be recognized by the National Institutes of Health.
- For marital counseling.
- For the medical treatment of sexual problems not caused by a biological disease.
- For transsexual surgery or any treatment leading to, or in connection with transsexual surgery.
- For birth control devices which include, but are limited to, IUD's and diaphragms.
- For reverse sterilization.
- For artificial insemination or in vitro fertilization.
- For hypnosis and acupuncture.
- For fraudulent or misrepresented claims.

Consult your Certificate of Coverage for a complete listing of benefits and exclusions.

NOTES:

Deductible expenses incurred for services by a network doctor or hospital will only apply to the network deductible. Deductible expenses incurred for services by a non-network doctor or hospital will only apply to the non-network deductible.

Coinsurance expenses incurred for services by a PPO network doctor or hospital will only apply to the PPO network coinsurance out-of-pocket. Coinsurance expenses incurred for services by a Non-PPO network doctor or hospital will only apply to the Non-PPO network coinsurance out-of-pocket.

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. No person other than an officer of Medical Mutual may agree, verbally or in writing, to change the benefits listed here. The contract or certificate 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 healthcare professional's billed charges or Medical Mutual's negotiated rate with the healthcare professional.

