

One SuperMed Benefit Highlights



MEDICAL MUTUAL®



SuperMed One
Elite Plans with Office Copay



| Base Plan | 500 | 1000 | 1500 | 2500 |
|---|------------------|------------------|------------------|------------------|
| Network 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 |
| Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family | \$2,500/\$5,000 | \$2,500/\$5,000 | \$2,500/\$5,000 | \$2,500/\$5,000 |
| Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family | \$5,000/\$10,000 | \$5,000/\$10,000 | \$5,000/\$10,000 | \$5,000/\$10,000 |
| Office Visit (OV) Copay | | | \$30 | |
| Specialist Visit (SV) Copay | | | \$40 | |
| Urgent Care (UC) Copay | | | \$50 | |
| Coinsurance Network/Non-Network | | | 80% / 50% | |
| Overall Annual Benefit Period Maximum | | | \$7,500,000 | |

| Benefits | PPO Network | Non-PPO Network |
|--|---|-----------------------------------|
| Benefit Period | January 1 st through December 31 st | |
| Dependent Age Limit | 28; Removal upon End of the Month | |
| Physician/Office Services | | |
| Office Visit (Illness/Injury) | \$30 copay, then 100% | 50% after deductible |
| Specialty Office Visit | \$40 copay, then 100% | 50% after deductible |
| Urgent Care Office Visit | \$50 copay, then 100% | \$50 copay, then 100% |
| Standard Immunizations | 80% after deductible | 50% after deductible ¹ |
| Preventive Services | | |
| Preventive Services, in accordance with state and federal law ² | 100% | 50% after deductible ¹ |
| Routine Physical Exam | 100% | 50% after deductible ¹ |
| Well Child Care Services to age nine. | | |
| Well Child Care Exams | 100% | 50% after deductible ¹ |
| Well Child Care Immunizations & Labs | 80% after deductible ³ | 50% after deductible |
| Routine Mammogram (one per benefit period) | 100% | 50% after deductible |
| Routine Pap Test (one per benefit period) | 100% | 50% after deductible |
| Routine EKG, Chest X-ray, Comprehensive Metabolic Panel, Urinalysis and Complete Blood Count (one each per benefit period) | 80% after deductible | 50% after deductible |
| Outpatient Services | | |
| Allergy Testing and Treatments | 80% after deductible | 50% after deductible ¹ |
| Physical Therapy (20 visits per benefit period) | 80% after deductible | 50% after deductible |
| Occupational Therapy (20 visits per benefit period) | 80% after deductible | 50% after deductible |
| Speech Therapy (20 visits per benefit period) | 80% after deductible | 50% after deductible |
| Chiropractic Services (12 visits per benefit period) | 80% after deductible | 50% after deductible |
| Cardiac Rehabilitation (20 visits per benefit period) | 80% after deductible | 50% after deductible |
| Emergency Use of an Emergency Room | 80% after deductible | |
| Non-Emergency Use of an Emergency Room | 80% after deductible | 50% after deductible |
| Surgical Services | 80% after deductible | 50% after deductible |
| Diagnostic Services | 80% after deductible | 50% after deductible |
| Inpatient Services | | |
| Semi-Private Room and Board | 80% after deductible | 50% after deductible |
| Skilled Nursing Facility (100 days per benefit period) | 80% after deductible | 50% after deductible |
| Additional Services | | |
| Ambulance | 80% after deductible | |
| Durable Medical Equipment | 80% after deductible | 50% after deductible |
| Home Health Care (60 days per benefit period) | 80% after deductible | 50% after deductible ¹ |
| Hospice | 80% after deductible | 50% after deductible ¹ |
| Organ and Tissue Transplants | 80% after deductible | 50% after deductible |

continued on page 2



**SuperMed One
Elite Plans with Office Copay**



| Benefits | PPO Network | Non-PPO Network |
|--|---|-----------------------------------|
| Mental Health & Substance Abuse | | |
| Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period, three admissions per lifetime) | 80% after deductible | 50% after deductible ¹ |
| Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period) | 50% after deductible ¹ | 50% after deductible ¹ |
| Prescription Drug – Oral Contraceptives Included⁴ | | |
| Retail – 30 Day Supply | \$15 Generic / \$30 Formulary / \$60 Non-Formulary | |
| Home Delivery – 90 Day Supply | \$45 Generic / \$90 Formulary / \$180 Non-Formulary | |
| Optional Riders | | |
| Maternity Rider | | |
| Benefits are payable after 270 days of coverage under maternity rider, subject to a \$1,500 maternity deductible | 80% after maternity deductible | 50% after maternity deductible |

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, orally 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 provider's billed charges or Medical Mutual's negotiated rate with the provider.

Deductible and coinsurance expenses incurred for services by a network provider will only apply to the network deductible and coinsurance out-of-pocket. Deductible and coinsurance expenses incurred for services by a non-network provider will only apply to the non-network deductible and coinsurance out-of-pocket.

The coinsurance for non-contracting institutional providers will be the same coinsurance percentage as the non-network provider. However, you may be subject to balance billing by the non-contracting provider.

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 the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

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

² 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.

³ Services are paid at percentage indicated unless it is a preventive service which includes 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.

⁴ 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 copayment 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 copayment.



SuperMed One
Elite Plans without Office Copay



| Base Plan | 2500 | 5000 | 10000 |
|---|------------------|-------------------|-------------------|
| Network 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 Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family | N/A | N/A | N/A |
| Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family | \$4,000/\$8,000 | \$4,000/\$8,000 | \$4,000/\$8,000 |
| Coinsurance Network/Non-Network | | 100% / 50% | |
| Overall Annual Benefit Period Maximum | | \$7,500,000 | |

| Benefits | PPO Network | Non-PPO Network |
|--|---|-----------------------------------|
| Benefit Period | January 1 st through December 31 st | |
| Dependent Age Limit | 28; Removal upon End of the Month | |
| Physician/Office Services | | |
| Office Visit (Illness/Injury) | 100% after deductible | 50% after deductible |
| Urgent Care Office Visit | 100% after deductible | 50% after deductible |
| Standard Immunizations | 100% after deductible | 50% after deductible ¹ |
| Preventive Services | | |
| Preventive Services, in accordance with state and federal law ² | 100% | 50% after deductible ¹ |
| Routine Physical Exam | 100% | 50% after deductible ¹ |
| Well Child Care Services to age nine. Well Child Care Exams | 100% | 50% after deductible ¹ |
| Well Child Care Immunizations & Labs | 100% after deductible ³ | 50% after deductible |
| Routine Mammogram (one per benefit period) | 100% | 50% after deductible |
| Routine Pap Test (one per benefit period) | 100% | 50% after deductible |
| Routine EKG, Chest X-ray, Comprehensive Metabolic Panel, Urinalysis and Complete Blood Count (one each per benefit period) | 100% after deductible | 50% after deductible |
| Outpatient Services | | |
| Allergy Testing and Treatments | 100% after deductible | 50% after deductible ¹ |
| Physical Therapy (20 visits per benefit period) | 100% after deductible | 50% after deductible |
| Occupational Therapy (20 visits per benefit period) | 100% after deductible | 50% after deductible |
| Speech Therapy (20 visits per benefit period) | 100% after deductible | 50% after deductible |
| Chiropractic Services (12 visits per benefit period) | 100% after deductible | 50% after deductible |
| Cardiac Rehabilitation (20 visits per benefit period) | 100% after deductible | 50% after deductible |
| Emergency Use of an Emergency Room | 100% after deductible | |
| Non-Emergency Use of an Emergency Room | 100% after deductible | 50% after deductible |
| Surgical Services | 100% after deductible | 50% after deductible |
| Diagnostic Services | 100% after deductible | 50% after deductible |
| Inpatient Services | | |
| Semi-Private Room and Board | 100% after deductible | 50% after deductible |
| Skilled Nursing Facility (100 days per benefit period) | 100% after deductible | 50% after deductible |
| Additional Services | | |
| Ambulance | 100% after deductible | |
| Durable Medical Equipment | 100% after deductible | 50% after deductible |
| Home Health Care (60 days per benefit period) | 100% after deductible | 50% after deductible ¹ |
| Hospice | 100% after deductible | 50% after deductible ¹ |
| Organ and Tissue Transplants | 100% after deductible | 50% after deductible |

continued on page 4



SuperMed One
Elite Plans without Office Copay



| Benefits | PPO Network | Non-PPO Network |
|--|---|-----------------------------------|
| Mental Health & Substance Abuse | | |
| Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period, three admissions per lifetime) | 100% after deductible | 50% after deductible ¹ |
| Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period) | 50% after deductible ¹ | 50% after deductible ¹ |
| Prescription Drug – Oral Contraceptives Included³ | | |
| Retail – 30 Day Supply | \$15 Generic / \$30 Formulary / \$60 Non-Formulary | |
| Home Delivery – 90 Day Supply | \$45 Generic / \$90 Formulary / \$180 Non-Formulary | |
| Optional Riders | | |
| Maternity Rider | | |
| Benefits are payable after 270 days of coverage under maternity rider, subject to a \$1,500 maternity deductible | 100% after maternity deductible | 50% after maternity deductible |

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, orally 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 provider's billed charges or Medical Mutual's negotiated rate with the provider.

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

The coinsurance for non-contracting institutional providers will be the same coinsurance percentage as the non-network provider. However, you may be subject to balance billing by the non-contracting provider.

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 the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

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

²Preventive 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.

³Services are paid at percentage indicated unless it is a preventive service which includes 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.

⁴Drug 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 copayment 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 copayment



SuperMed One
Premium Plans with Office Copay



| Base Plan | 500 | 1000 | 1500 | 2500 |
|---|-------------------|-------------------|-------------------|-------------------|
| Network 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 |
| Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family | \$10,000/\$20,000 | \$10,000/\$20,000 | \$10,000/\$20,000 | \$10,000/\$20,000 |
| Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family | \$10,000/\$20,000 | \$10,000/\$20,000 | \$10,000/\$20,000 | \$10,000/\$20,000 |
| Office Visit (OV) Copay | | | \$40 | |
| Specialist Visit (SV) Copay | | | \$50 | |
| Urgent Care (UC) Copay | | | \$75 | |
| Coinsurance Network/Non-Network | | | 80% / 50% | |
| Overall Annual Benefit Period Maximum | | | \$7,500,000 | |

| Benefits | PPO Network | Non-PPO Network |
|--|---|-----------------------------------|
| Benefit Period | January 1 st through December 31 st | |
| Dependent Age Limit | 28; Removal upon End of the Month | |
| Physician/Office Services | | |
| Office Visit (Illness/Injury) | \$40 copay, then 100% | 50% after deductible |
| Specialty Office Visit | \$50 copay, then 100% | 50% after deductible |
| Urgent Care Office Visit | \$75 copay, then 100% | \$75 copay, then 100% |
| Standard Immunizations | 80% after deductible | 50% after deductible ¹ |
| Preventive Services | | |
| Preventive Services, in accordance with state and federal law ² | 100% | 50% after deductible ¹ |
| Routine Physical Exam | 100% | 50% after deductible ¹ |
| Well Child Care Services to age nine. | | |
| Well Child Care Exams | 100% | 50% after deductible ¹ |
| Well Child Care Immunizations & Labs | 80% after deductible ³ | 50% after deductible |
| Routine Mammogram (one per benefit period) | 100% | 50% after deductible |
| Routine Pap Test (one per benefit period) | 100% | 50% after deductible |
| Routine EKG, Chest X-ray, Comprehensive Metabolic Panel, Urinalysis and Complete Blood Count (one each per benefit period) | 80% after deductible | 50% after deductible |
| Outpatient Services | | |
| Allergy Testing and Treatments | 80% after deductible | 50% after deductible ¹ |
| Physical Therapy (20 visits per benefit period) | 80% after deductible | 50% after deductible |
| Occupational Therapy (20 visits per benefit period) | 80% after deductible | 50% after deductible |
| Speech Therapy (20 visits per benefit period) | 80% after deductible | 50% after deductible |
| Chiropractic Services (12 visits per benefit period) | 80% after deductible | 50% after deductible |
| Cardiac Rehabilitation (20 visits per benefit period) | 80% after deductible | 50% after deductible |
| Emergency Use of an Emergency Room | 80% after deductible | |
| Non-Emergency Use of an Emergency Room | 80% after deductible | 50% after deductible |
| Surgical Services | 80% after deductible | 50% after deductible |
| Diagnostic Services | 80% after deductible | 50% after deductible |
| Inpatient Services | | |
| Semi-Private Room and Board | 80% after deductible | 50% after deductible |
| Skilled Nursing Facility (100 days per benefit period) | 80% after deductible | 50% after deductible |
| Additional Services | | |
| Ambulance | 80% after deductible | |
| Durable Medical Equipment | 80% after deductible | 50% after deductible |
| Home Health Care (60 days per benefit period) | 80% after deductible | 50% after deductible ¹ |
| Hospice | 80% after deductible | 50% after deductible ¹ |
| Organ and Tissue Transplants | 80% after deductible | 50% after deductible |

continued on page 6



SuperMed One
Premium Plans with Office Copay



| Benefits | PPO Network | Non-PPO Network |
|--|---|-----------------------------------|
| Mental Health & Substance Abuse | | |
| Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period, three admissions per lifetime) | 80% after deductible | 50% after deductible ¹ |
| Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period) | 50% after deductible ¹ | 50% after deductible ¹ |
| Prescription Drug – Oral Contraceptives Included⁴ | | |
| Retail – 30 Day Supply | \$15 Generic / \$30 Formulary / \$60 Non-Formulary | |
| Home Delivery – 90 Day Supply | \$45 Generic / \$90 Formulary / \$180 Non-Formulary | |
| Optional Riders | | |
| Maternity Rider | | |
| Benefits are payable after 270 days of coverage under maternity rider, subject to a \$1,500 maternity deductible | 80% after maternity deductible | 50% after maternity deductible |

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Deductible and coinsurance expenses incurred for services by a network provider will only apply to the network deductible and coinsurance out-of-pocket. Deductible and coinsurance expenses incurred for services by a non-network provider will only apply to the non-network deductible and coinsurance out-of-pocket.

The coinsurance for non-contracting institutional providers will be the same coinsurance percentage as the non-network provider. However, you may be subject to balance billing by the non-contracting provider.

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 the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

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

² 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.

³Services are paid at percentage indicated unless it is a preventive service which includes 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.

⁴Drug 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 copayment 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 copayment



MEDICAL MUTUAL OF OHIO®

SuperMed One
Wellness HSA Plans



| Base Plan | 1500 | 2500 | 3000 | 5000 |
|---|------------------------------|------------------|------------------|-------------------|
| Network Benefit Period Deductible Single/Family | \$1,500/\$3,000 ¹ | \$2,500/\$5,000 | \$3,000/\$6,000 | \$5,000/\$10,000 |
| Non-Network Benefit Period Deductible Single/Family | \$3,000/\$6,000 ¹ | \$5,000/\$10,000 | \$6,000/\$12,000 | \$10,000/\$20,000 |
| Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family | N/A | N/A | N/A | N/A |
| Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family | \$4,000/\$8,000 ² | \$4,000/\$8,000 | \$4,000/\$8,000 | \$4,000/\$8,000 |
| Coinsurance Network/Non-Network | 100% / 50% | | | |
| Overall Annual Benefit Period Maximum | \$7,500,000 | | | |

| Benefits | PPO Network | Non-PPO Network |
|--|---|----------------------|
| Benefit Period | January 1 st through December 31 st | |
| Dependent Age Limit | 28; Removal upon End of the Month | |
| Physician/Office Services | | |
| Office Visit (Illness/Injury) | 100% after deductible | 50% after deductible |
| Specialty Office Visit | 100% after deductible | 50% after deductible |
| Urgent Care Office Visit | 100% after deductible | 50% after deductible |
| Standard Immunizations | 100% after deductible | 50% after deductible |
| Preventive Services | | |
| Preventive Services, in accordance with state and federal law ³ | 100% | 50% after deductible |
| Routine Physical Exam | 100% | 50% after deductible |
| Well Child Care Services to age nine. | | |
| Well Child Care Exams, Immunizations & Labs | 100% | 50% after deductible |
| Routine Mammogram (one per benefit period) | 100% | 50% after deductible |
| Routine Pap Test (one per benefit period) | 100% | 50% after deductible |
| Routine PSA, Cholesterol, Colon Cancer Screening Tests, Bone Density Tests and Endoscopic Services | 100% | 50% after deductible |
| Routine EKG, Chest X-ray, Comprehensive Metabolic Panel, Urinalysis and Complete Blood Count (one each per benefit period) | 100% | 50% after deductible |
| Outpatient Services | | |
| Allergy Testing and Treatments | 100% after deductible | 50% after deductible |
| Physical Therapy (20 visits per benefit period) | 100% after deductible | 50% after deductible |
| Occupational Therapy (20 visits per benefit period) | 100% after deductible | 50% after deductible |
| Speech Therapy (20 visits per benefit period) | 100% after deductible | 50% after deductible |
| Chiropractic Services (12 visits per benefit period) | 100% after deductible | 50% after deductible |
| Cardiac Rehabilitation (20 visits per benefit period) | 100% after deductible | 50% after deductible |
| Emergency Use of an Emergency Room | 100% after deductible | |
| Non-Emergency Use of an Emergency Room | 100% after deductible | 50% after deductible |
| Surgical Services | 100% after deductible | 50% after deductible |
| Diagnostic Services | 100% after deductible | 50% after deductible |
| Diagnostic Endoscopic Services | 100% | 50% after deductible |
| Inpatient Services | | |
| Semi-Private Room and Board | 100% after deductible | 50% after deductible |
| Skilled Nursing Facility (100 days per benefit period) | 100% after deductible | 50% after deductible |
| Additional Services | | |
| Ambulance | 100% after deductible | 50% after deductible |
| Durable Medical Equipment | 100% after deductible | 50% after deductible |
| Home Health Care (60 days per benefit period) | 100% after deductible | 50% after deductible |
| Hospice | 100% after deductible | 50% after deductible |
| Organ and Tissue Transplants | 100% after deductible | 50% after deductible |

continued on page 8



SuperMed One
Wellness HSA Plans



| Benefits | PPO Network | Non-PPO Network |
|--|-----------------------|-----------------------------------|
| Mental Health & Substance Abuse | | |
| Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period, three admissions per lifetime) | 100% after deductible | 50% after deductible ⁴ |
| Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period) | 100% after deductible | 50% after deductible ⁴ |
| Prescription Drug – Oral Contraceptives Included (Failure to present an ID card may result in increased cost.) | | |
| Retail – 90 Day Supply Home Delivery – 90 Day Supply | 100% after deductible | |

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, orally 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 provider's billed charges or Medical Mutual's negotiated rate with the provider.

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

The coinsurance for non-contracting institutional providers will be the same coinsurance percentage as the non-network provider. However, you may be subject to balance billing by the non-contracting provider.

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 the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

¹Maximum family deductible. Family deductible must be met before benefits are provided on a family contract. The single deductible applies to single contracts.
²Maximum family coinsurance out-of-pocket. Family coinsurance out-of-pocket must be met before all benefits are paid at 100% on a family contract. The single coinsurance out-of-pocket applies to single contracts.
³Preventive 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.
⁴Coinurance does not apply to coinsurance out-of-pocket maximums. These services will not be covered at 100% once Coinsurance out-of-pocket maximums are met.



SuperMed One Value Plans



| Base Plan | 500 | 1000 | 1500 |
|---|------------------|------------------|------------------|
| Network 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 |
| Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family | \$3,500/\$7,000 | \$4,000/\$8,000 | \$4,500/\$9,000 |
| Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family | \$7,500/\$15,000 | \$8,000/\$16,000 | \$8,500/\$17,000 |
| Coinsurance Network/Non-Network | 70% / 50% | | |
| Overall Annual Benefit Period Maximum | \$7,500,000 | | |

| Benefits | PPO Network | Non-PPO Network |
|--|---|-----------------------------------|
| Benefit Period | January 1 st through December 31 st | |
| Dependent Age Limit | 28; Removal upon End of the Month | |
| Physician/Office Services | | |
| Office Visit (Illness/Injury) | 70% after deductible | 50% after deductible |
| Specialty Office Visit | 70% after deductible | 50% after deductible |
| Urgent Care Office Visit | 70% after deductible | 50% after deductible |
| Standard Immunizations | 70% after deductible | 50% after deductible ¹ |
| Preventive Services | | |
| Preventive Services, in accordance with state and federal law ² | 100% | 50% after deductible ¹ |
| Routine Physical Exam | 100% | 50% after deductible |
| Well Child Care Services to age nine. | | |
| Well Child Care Exams, Immunizations & Labs | 70% after deductible ³ | 50% after deductible |
| Routine Mammogram (one per benefit period) | 100% | 50% after deductible |
| Routine Pap Test (one per benefit period) | 100% | 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 |
| Physical Therapy (10 visits per benefit period) | 70% after deductible | 50% after deductible |
| Occupational Therapy (10 visits per benefit period) | 70% after deductible | 50% after deductible |
| Speech Therapy (10 visits per benefit period) | 70% after deductible | 50% after deductible |
| Chiropractic Services (6 visits per benefit period) | 70% after deductible | 50% after deductible |
| Cardiac Rehabilitation | NOT COVERED | |
| Emergency Use of an Emergency Room | 70% after deductible | |
| Non-Emergency Use of an Emergency Room | NOT COVERED | |
| Surgical Services | 70% after deductible | 50% after deductible |
| Diagnostic Services | 70% after deductible | 50% after deductible |
| Inpatient Services | | |
| Semi-Private Room and Board | 70% after deductible | 50% after deductible |
| Skilled Nursing Facility (100 days per benefit period) | 70% after deductible | 50% after deductible |
| Additional Services | | |
| Ambulance | 70% after deductible | |
| Durable Medical Equipment | 50% after deductible | 50% after deductible |
| Home Health Care (60 days per benefit period) | 70% after deductible | 50% after deductible ¹ |
| Hospice | 70% after deductible | 50% after deductible ¹ |
| Organ and Tissue Transplants | 70% after deductible | 50% after deductible |

continued on page 10



SuperMed One Value Plans



| Benefits | PPO Network | Non-PPO Network |
|---|---|-----------------------------------|
| Mental Health & Substance Abuse | | |
| Inpatient Mental Health and Substance Abuse Services (10 days per benefit period) | 70% after deductible | 50% after deductible ¹ |
| Outpatient Mental Health and Substance Abuse Services (10 visits per benefit period) | 50% after deductible ¹ | 50% after deductible ¹ |
| Prescription Drug | | |
| Retail – 30 Day Supply | \$15 copay – Generic drug only ⁴ | |
| Home Delivery – 90 Day Supply | NOT COVERED | |

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, orally 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 provider's billed charges or Medical Mutual's negotiated rate with the provider.

Deductible and coinsurance expenses incurred for services by a network provider will only apply to the network deductible and coinsurance out-of-pocket. Deductible and coinsurance expenses incurred for services by a non-network provider will only apply to the non-network deductible and coinsurance out-of-pocket.

The coinsurance for non-contracting institutional providers will be the same coinsurance percentage as the non-network provider. However, you may be subject to balance billing by the non-contracting provider.

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 the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

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

²Preventive 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.

³Services are paid at percentage indicated unless it is a preventive service which includes 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.

⁴The 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.

| Base Plan | 250 | 500 | 1000 | 1500 |
|--|-------------------|-----------------|-----------------|-----------------|
| Network Benefit Period Deductible Single/Family | \$250/\$500 | \$500/\$1,000 | \$1,000/\$2,000 | \$1,500/\$3,000 |
| Non-Network Benefit Period Deductible Single/Family | \$500/\$1,000 | \$1,000/\$2,000 | \$2,000/\$4,000 | \$3,000/\$6,000 |
| Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family | \$5,000/\$10,000 | | | |
| Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family | \$10,000/\$20,000 | | | |
| Office Visit (OV) Copay | \$30 | | | |
| Specialty Visit (SP) Copay | \$40 | | | |
| Urgent Care (UC) Copay | \$50 | | | |
| Coinsurance Network/Non-Network | 80% / 50% | | | |
| Overall Annual Benefit Period Maximum | \$7,500,000 | | | |

| Benefits | PPO Network | Non-PPO Network |
|--|---|-----------------------------------|
| Benefit Period | January 1 st through December 31 st | |
| Dependent Age Limit | 28; Removal upon End of the Month | |
| Physician/Office Services | | |
| Office Visit (Illness/Injury) | \$30 copay, then 100% | \$30 copay, then 50% |
| Specialty Office Visit | \$40 copay, then 100% | \$40 copay, then 50% |
| Urgent Care Office Visit | \$50 copay, then 100% | \$50 copay, then 50% |
| Standard Immunizations | 80% after deductible | 50% after deductible ¹ |
| Preventive Services | | |
| Well Child Care Services to age nine. Exams and Immunizations are limited to \$500 per child to age one; thereafter, \$150 per child per birth year to age nine) | | |
| Well Child Care Exams, Immunizations & 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 |
| Outpatient Services | | |
| Allergy Testing and Treatments | 80% after deductible | 50% after deductible ¹ |
| Physical Therapy (10 visits per benefit period) | 80% after deductible | 50% after deductible |
| Occupational Therapy (10 visits per benefit period) | 80% after deductible | 50% after deductible |
| Speech Therapy (10 visits per benefit period) | 80% after deductible | 50% after deductible |
| Chiropractic Services (10 visits per benefit period) | 80% after deductible | 50% after deductible |
| Cardiac Rehabilitation | 80% after deductible | 50% after deductible |
| Emergency Use of an Emergency Room | \$100 copay, then 80% | |
| Non-Emergency Use of an Emergency Room | \$100 copay, then 80% | \$100 copay, then 50% |
| Surgical Services | 80% after deductible | 50% after deductible |
| Diagnostic Services | 80% after deductible | 50% after deductible |
| Inpatient Services | | |
| 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 | \$100 copay, then 80% | |
| Durable Medical Equipment | 80% after deductible | 50% after deductible |
| Home Health Care (60 days per benefit period) | 80% after deductible | 50% after deductible ¹ |
| Hospice | 80% after deductible | 50% after deductible ¹ |
| Organ and Tissue Transplants | 80% after deductible | 50% after deductible |



MEDICAL MUTUAL OF OHIO®

SuperMed One Short Term Plans



| Benefits | PPO Network | Non-PPO Network |
|---|-----------------------------------|-----------------------------------|
| Mental Health & Substance Abuse | | |
| Inpatient Alcoholism (30 days per benefit period) | 80% after deductible | 50% after deductible ¹ |
| Outpatient Alcoholism (20 visits per benefit period) | 50% after deductible ¹ | 50% after deductible ¹ |
| Prescription Drug – Oral Contraceptives Included | | |
| Prescription Drug Benefit Period Deductible – Single/Family | \$250/\$500 | |
| Prescription Drug Benefit Period Maximum | \$500 | |
| Prescription Drug Lifetime Maximum | \$2,500,000 | |
| Retail – 30 Day Supply | 80% after deductible | |
| Home Delivery – 90 Day Supply | NOT COVERED | |

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, orally 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 provider's billed charges or Medical Mutual's negotiated rate with the provider.

Deductible and coinsurance expenses incurred for services by a network provider will only apply to the network deductible and coinsurance out-of-pocket. Deductible and coinsurance expenses incurred for services by a non-network provider will only apply to the non-network deductible and coinsurance out-of-pocket.

The coinsurance for non-contracting institutional providers will be the same coinsurance percentage as the non-network provider. However, you may be subject to balance billing by the non-contracting provider.

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 the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

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



SuperMed One Vision
EyeMed Access Network



| Services | Network | Non-Network ¹ |
|---|--|--|
| Dependent Age Limit | 28; Removal upon End of Month | |
| Professional Services (One every 12 months) Spectacle exam Contact lens exam | \$15 copayment \$15 copayment + any amount over spectacle exam | \$15 maximum \$15 maximum |
| Frame (One every 12 months) | \$0 copayment (Up to \$100. 20% off anything more than \$100) | \$30 maximum |
| Lenses (Uncoated plastic. One pair every 12 months) Single vision Bifocal Trifocal Lenticular | \$15 copayment \$15 copayment \$15 copayment \$15 copayment | \$10 maximum \$20 maximum \$30 maximum \$40 maximum |
| Contact Lenses (In lieu of lenses and frames. One pair every 12 months) Cosmetic Medically necessary Disposable | \$15 copayment (up to \$100) \$15 copayment (up to \$200) \$15 copayment (up to \$100) | \$40 maximum \$75 maximum \$40 maximum |

Listed below are additional ways to save on lens options and contact lenses through the SuperMed Vision program.

Lens options: If an 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 | Lens options | *Discounted price |
|-------------------------------------|-------------------|-----------------------------------|----------------------|
| Progressive (no-line bifocal) | \$65 | Anti-reflective coating | \$45 |
| Polycarbonate | \$40 | Solid tint or Gradient tint | \$15 |
| Scratch-resistant coating | \$15 | Photochromic | 20% off retail price |
| Ultraviolet coating | \$15 | Glass | 20% off retail price |

* Discounted price is in addition to the \$15 copayment listed above. Discounts available through EyeMed Access providers only.

Contact lenses: Listed below are two convenient ways to obtain 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.

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

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, orally or in writing, to change the benefits listed here. The contract or certificate will contain the complete listing of covered services.

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



MEDICAL MUTUAL OF OHIO®

SuperMed One
DentalBenefits



| Benefits | Network | Non-Network |
|--|---|----------------------|
| Benefit Period | January 1 st through December 31 st | |
| Dependent Age Limit | 25 Dependent, 25 Student; Removal 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

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.



Life Insurance Highlights



The following is an overview of your life insurance options. Once a policy is issued, a certificate of insurance will be available to explain your coverage in detail.

What is life insurance?

Life insurance pays your beneficiary (please see below) a benefit if you die while you are covered by the policy, thus ensuring financial security in the event of your death.

How much life insurance can I purchase?

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

Am I guaranteed coverage?

When you enroll, you are guaranteed life coverage valued at \$50,000 – no medical information is required.

What is a beneficiary?

Your beneficiary is the person (or persons) or legal entity (entities) who receives a benefit payment if you die while you are insured.

Are there other limitations to enrollment?

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

Life insurance coverage for your spouse

You may choose to purchase Life Insurance coverage for your spouse 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.

Life insurance coverage for your children

You may choose to purchase Life Insurance coverage 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.

How long are the initial rates guaranteed?

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

When does coverage terminate?

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.

continued on page 16

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.

