



SuperMed

Benefit Highlights



MEDICAL MUTUAL OF OHIO®



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

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**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.

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.
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

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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

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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.

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



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

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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	

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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.
⁴Coinsurance 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.



MEDICAL MUTUAL OF OHIO®

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

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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.



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.

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.