# Summary of Health Care Coverage for All Eligible Bargaining Unit Employees and all Eligible Exempt Professional Administrative and Exempt Classified Employees Effective 01/01/09

**THESE SUMMARIES ARE PROVIDED FOR YOUR INFORMATION. PLEASE REFER TO YOUR CERTIFICATE BOOK FOR MORE SPECIFIC QUESTIONS**.

For information on **Medical Mutual claims**, to order new **ID cards**, or to **change your address** please call 1-800-521-6492 or visit the Medical Mutual website at http://MedMutual.com.

**PLEASE NOTE: IT IS THE EMPLOYEES RESPONSIBILITY TO NOTIFY THE INSURANCE COMPANY WITHIN 30 DAYS OF ANY LIFE CHANGING EVENT (I.E., BIRTH, DEATH, DIVORCE, NAME OR ADDRESS CHANGE).**

| | SUPERMED CLASSIC (REPLACES TRADITIONAL)† | SUPERMED SELECT | SUPERMED HMO (REPLACES ANTHEM) |
|---|---|---|---|
| **Network** | Hospital only | Hospital & Physician<br>Must Select Primary Care Physician (PCP). Referrals are not needed to see in Network specialists. | Hospital & Physician<br>Must Select Primary Care Physician (PCP) Referrals are not needed to see in Network. specialists |
| **Dependent Age** | The end of the year of the 25th birthday | The end of the year of the 25th birthday | The end of the year of the 25th birthday |
| **Deductible** | $200 / $400 | $100 / $300 for Non-Authorized Services | N/A |
| **Coinsurance Limits** | In-Network -15% Coinsurance until $225 / $450<br>Non-Network-<br>25% Coinsurance until<br>$725 / $950† | $1,200 /$2,400 for Non-Authorized Services | N/A |
| † The University will reimburse bargaining unit members enrolled in the SuperMed Classic plan (or subsequent comparable plans) for out of network charges incurred by the bargaining unit member of his/her covered dependents as a result of use of a non-network hospital. | | | |
| **Annual Out-of-Pocket Maximum (including Deductible).**<br>**Office Visit Co pays Do Not Count Toward Annual Maximum** | In-Network<br>$425 / $850<br><br>Non-Network<br>$925 / $1,350 | N/A<br><br>$1,300/$2,700 for Non-Authorized Services | $3,000/$6,000 |
| **Benefit Period** | Calendar Year (January 1 through December 31) | Calendar Year (January 1 through December 31) | Calendar Year (January 1 through December 31) |
| **Pre-existing Period** | No Waiting Period | No Waiting Period | No Waiting Period |
| **Lifetime Maximum** | $2,000,000 | $2,500,000 | Unlimited |

## PHYSICIAN OFFICE SERVICES

| | | | |
|---|---|---|---|
| **Office Visits** | $10 Co- payment [1] | $10 Co- payment [1] | $10 Co- payment [1] |
| **Office Surgeries** | 15% of Coinsurance After Deductible | $10 Co-payment | $10 Co-payment |
| **Preconception Care/Education** | 15% of Coinsurance After Deductible | $10 Co-payment [1] | $10 Co-payment [1] |
| **Allergy – Testing** | 15% of Coinsurance After Deductible In Network<br><br>25% of Coinsurance After Deductible Non-Network | Covered in Full in Network<br><br>Non Authorized Services; 80% Coinsurance after Deductible – Inpatient care<br>Non Authorized Services; 50% Coinsurance after Deductible – Outpatient care | Covered in Full in Network |
| **Allergy ─ Treatment Serum & Injections** | 15% of Coinsurance In Network | Covered in Full in Network<br><br>Non Authorized Services; 80% Coinsurance after Deductible – Inpatient care<br>Non Authorized Services; 50% Coinsurance after Deductible – Outpatient care | Covered in Full in Network |

[1]$10 co-payment if seen by a physician

## PREVENTIVE CARE

| | | | |
|---|---|---|---|
| **Routine Physical Exam, Routine Lab, X-Ray and Medical Tests** | Covered in Full<br>1 per benefit period | Covered in Full<br>1 per benefit period | Covered in Full in Network<br>1 per benefit period |
| **Mammography and Pelvic Exams, PAP Test, and PSA Test** | Covered in Full<br>1 per benefit period | Covered in Full<br>1 per benefit period | Covered in Full in Network<br>1 per benefit period |
| **Immunizations, Annual Diabetic Eye Exam** | Covered in Full<br>1 per benefit period | Covered in Full<br>1 per benefit period | Covered in Full in Network<br>1 per benefit period |
| **Routine Colonoscopy** | Covered in Full | Covered in Full | Covered in Full in Network |
| **Vision Exams** | Routine basic eye exam by PCP (internal general or family practice doctor) covered in full. Does not include ophthalmologist or optometrist<br>1 per benefit period | Routine basic eye exam by PCP (internal general or family practice doctor) covered in full. Does not include ophthalmologist or optometrist<br>1 per benefit period | Exam given by Network ophthalmologist or optometrist covered in full.<br>1 per benefit period |
| **Hearing Exams** | Covered in Full<br>1 per benefit period | Covered in Full<br>1 per benefit period | Covered in Full in Network<br>1 per benefit period |

| | | | |
|---|---|---|---|
| **PHYSICAL REHABILITATION** | | | |
| **Physical and Occupational*** | 15% Coinsurance after Deductible | Covered in full | Covered in full in Network, 60 visit maximum |
| **Spinal Manipulation** [3] | 15% Coinsurance after Deductible<br><br>[3]25 visit maximum combined for Physical/Occupational Therapy and Spinal Manipulation | Covered in full<br><br>[3]25 visit maximum combined for Physical/Occupational Therapy and Spinal Manipulation | Covered in full in Network<br><br>12 visit maximum |
| **OUTPATIENT SERVICES** | | | |
| **Surgical Services** | In-Network; 15% Coinsurance after Deductible<br><br>Non-Network; 25% Coinsurance after Deductible | Covered in Full in Network<br><br>Non Authorized Services; 80% Coinsurance after Deductible | Covered in Full in Network |
| **Speech Therapy** | 15% Coinsurance, after Deductible, 15 Visit Maximum | Covered in Full, 15 Visit Maximum | Covered in Full in Network, 20 Visit maximum |
| **Cardiac Rehabilitation** | In-Network; 15% Coinsurance, after Deductible | Covered in Full | Covered in Full in Network |
| **Radiation & Chemotherapy – includes Oral Therapy** | In-Network; 15% Coinsurance after Deductible<br><br>Non-Network; 25% Coinsurance after Deductible | Covered in Full in Network<br><br>Non Authorized Services; 80% Coinsurance after Deductible | Covered in Full in Network |
| **Diagnostic Services** | In-Network; 15% Coinsurance after Deductible<br><br>Non-Network; 25% Coinsurance after Deductible | Covered in Full | Covered in Full in Network |
| **Respiratory Therapy & Pulmonary Therapy** | In-Network; 15% Coinsurance after Deductible<br><br>Non-Network; 25% Coinsurance after Deductible | Covered in Full in Network<br><br>Non Authorized Services; 80% Coinsurance after Deductible | Covered in Full in Network |
| **Dialysis Treatments** | In-Network; 15% Coinsurance after Deductible<br><br>Non-Network; 25% Coinsurance after Deductible | Covered in Full in Network<br><br>Non Authorized Services; 80% Coinsurance after Deductible | Covered in Full in Network |
| **INPATIENT SERVICES** | | | |
| **Semi-Private Room and Board** | Network, 15% Coinsurance after Deductible<br><br>Non-network; 25% Coinsurance after Deductible | Covered in full in Network<br><br>Non-network; 20% Coinsurance after Deductible | Covered in full in Network |

| | | | |
|---|---|---|---|
| **Maternity Services** | 15% Coinsurance, after Deductible<br><br>Non-network; 25% coinsurance after deductible | Covered in full in Network<br><br>Non-network; 20% Coinsurance after Deductible | Covered in Full in Network |
| **Home Care Services**<br><br>**(Care must be non-custodial in nature and can not be for convenience)** | In-Network; 15% Coinsurance after Deductible<br><br>Non-Network; 25% Coinsurance after Deductible | Covered in Full in Network<br><br>Non Authorized Services; 50% | Covered in Full in Network |
| **Hospice Services** | In-Network; 15% Coinsurance after Deductible<br><br>Non-Network; 25% Coinsurance after Deductible | Covered in Full in Network<br><br>Non Authorized Services; 50% Coinsurance after Deductible | Covered in Full in Network |
| **Skilled Nursing Facility** | In-Network; 15% Coinsurance after Deductible<br><br>Non-Network; 25% Coinsurance after Deductible | Covered in full in Network<br>100 Days Per Benefit Period<br><br>Non-network; 20% Coinsurance after Deductible | Covered in Full in Network |
| **ADDITIONAL SERVICES** | | | |
| **Ambulance – Air Ambulance if medically necessary** | 15% Coinsurance after Deductible | Covered in Full | Covered in Full |
| **Durable Medical Equipment** | 15% Coinsurance after Deductible | Covered in Full | 20% Coinsurance |
| **Human Organ Transplant** | Covered in Full<br><br>**$1,000,000 per life time** | Covered in Full<br><br>**$1,000,000 per life time** | Covered in full in Network<br><br>**Unlimited** |
| **Initial Newborn Exam – Physician** | 15% Coinsurance after Deductible | Covered in full in Network<br><br>Non-network; 20% Coinsurance after Deductible | Covered in full in Network |
| **Private Duty Nurse** | 15% Coinsurance after Deductible<br><br>**$5,000 maximum per benefit period**<br>**(Must demonstrate medical necessity)** | Covered in full in Network<br><br>Non-network; 20% Coinsurance after Deductible<br><br>**$5,000 maximum per benefit period**<br>**(Must demonstrate medical necessity)** | Covered in full in Network<br><br>**Only available in conjunction with Home Health Care** |

| EMERGENCY CARE / URGENT CARE | | | |
|---|---|---|---|
| **Hospital Emergency Room Physician Services** | $10 Co-Pay<br>15% Coinsurance after Deductible;<br><br>Non-network; 25% Coinsurance after Deductible | Covered in full | Covered in full |
| **Hospital Emergency Room Facility Charges**<br><br>**Non-Emergency Use of Emergency Room** | In-Network; 15% coinsurance after deductible;<br><br>In-Network; 15% coinsurance after deductible<br>Non-network; 25% coinsurance after deductible. | Covered in full<br><br>Covered in full | Covered in full if admitted into hospital<br><br>$50 co-payment if not admitted into hospital |
| **Urgent Care: Physician Services**<br><br>**Urgent Care: Facility Charges** | $10 Co-payment<br><br>Network, 15% Coinsurance after Deductible<br>Non-network; 25% Coinsurance after Deductible. | $10 Co-payment<br><br>Non-network; 20% coinsurance after deductible | $25 co-payment |
| **MENTAL HEALTH AND SUBSTANCE ABUSE LIMITS AND MAXIMUMS APPLY** | | | |
| **Inpatient Care Mental Health/Substance Abuse** | In-Network; 15% coinsurance after deductible<br><br>Non-network; 25% coinsurance after deductible<br><br>Limited to 31 days combined in or out of network<br><br>Three admissions per lifetime | Covered in full in Network<br><br>Non-network; 50% Coinsurance after Deductible<br><br>Limited to 30 days combined in or out of network<br><br>Three admissions per lifetime | Covered in full in Network<br><br>Non-network: not covered<br><br>Limited to 30 days<br><br>Two admissions per lifetime |
| **Outpatient Care Mental Health/Substance Abuse** | In-Network; 15% coinsurance after deductible<br><br>Non-network; 25% coinsurance after deductible<br><br>Limited to 30 visits combined in or out of network | Covered in full in Network<br><br>Non-network; 50% Coinsurance after Deductible<br><br>Limited to 30 visits combined in or out of network | Covered in full in Network<br><br>Non-network: not covered<br><br>Limited to 50 visits |

| PRESCRIPTION DRUGS (INCLUDING ORAL CONTRACEPTIVES) | | |
|---|---|---|
| **Benefits** | **Co-pay** | **Day Supply** |
| **Benefit Period** | January 1st through December 31st | |
| **Dependent Age Limit** | 25; Removal End of Calendar Year | |
| **Formulary Retail Program with Oral Contraceptive Coverage** [1,2,3] | | |
| **Generic Co-pay** | $0 | 30 |
| **Formulary Co-pay** | $17 | 30 |
| **Non-Formulary Co-pay** | $35 | 30 |
| **Formulary Retail Program with Oral Contraceptive Coverage – after 2nd retail fill of prescription drug** | | |
| **Generic Co-pay** | Not Covered | |
| **Formulary Co-pay** | Not Covered | |
| **Non-Formulary Co-pay** | Not Covered | |
| **Formulary Mail Order Program with Oral Contraceptive Coverage** [1,2,3] | | |
| **Generic Co-pay** | $0 | 90 |
| **Formulary Co-pay** | $25 | 90 |
| **Non-Formulary Co-pay** | $50 | 90 |

Note: In an effort to continue our commitment to quality care and help contain the increasing cost of prescription drug coverage, a formulary feature is included in your prescription drug benefit. A formulary drug is a FDA approved prescription medication reviewed by an independent Pharmacy and Therapeutics Committee brought together by Medco Health Solutions, Inc. Formulary drugs can assist in maintaining quality care while meeting your plan's cost containment objectives.

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.

**Important Information for Diabetics**: you may be able to obtain diabetic supplies at no cost to you by participating in MMO's Diabetes Advantage program. If you have questions about the program and/or wish to enroll, please call 1-800-861-4826.

[1] Includes Rx Selections® Drug List: A list of drugs on the Rx Selections® formulary will be used.
[2] Diabetic Supplies, including over-the-counter items, as well as insulin, syringes and needles, glucose monitors and meters are covered. If insulin is purchased on the same day as supplies, then charge one co-pay. If insulin is not purchased on the same day as supplies, then each supply takes a separate co-pay including syringes.
[3] Allergy Serum is covered. Fertility Drugs, Growth Hormones and Weight Loss Drugs are excluded.
[4] Mandatory Home Delivery (Mail Order): When member chooses to fill a prescription, for a non-acute prescription drug, a third time at a retail pharmacy within 180 days, it will not be covered.