Boardman Township Trustees
SuperMed Plus
(Non Grandfathered)
Proposed Plan 1
4-1-2011

MEDICAL MUTUAL

SuperMed Plus

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit Over Aged Child	26 28 Removal upon End of Month	
Pre-Existing Condition Waiting Period (Does not apply to members under the age of 19)	Initial Group Waived, All Others 6-12	
Blood Pint Deductible	0 pints	
Overall Annual Benefit Period Maximum	$5,000,000	
Benefit Period Deductible – Single/Family[1]	$100 / $200	$200 / $400
Coinsurance	90%	80%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	$250 / $500	$1,000 / $2,000
Physician/Office Services		
PCP Office Visit (Illness/Injury)[2]	$15 Copay, then 100%	80% after deductible
Specialist Office Visit (Illness/Injury)[2]	$25 Copay, then 100%	80% after deductible
Urgent Care Office Visit[2]	$50 Copay, then 100%	80% after deductible
Surgical Services in Physicians Office	90% after deductible	80% after deductible
All Immunizations	100%	80% after deductible
Allergy Testing and Treatment	90% after deductible	80% after deductible
Therapeutic Injectables, Contraceptive Injectables, Drugs and Biologicals and Administration	90% after deductible	80% after deductible
Diabetic Education and Training including Medical Nutritional Therapy	90% after deductible	80% after deductible
Preventative Services		
Preventive Services, in accordance with state and federal law[3]	100%	80% after deductible
Routine Physical Exams (Age 21 and over)	100%	80% after deductible
Well Child Care Services including Exam, Routine Vision, Routine Hearing Exams, Well Child Care Immunizations and Laboratory Tests (Birth to age 21)	100%	80% after deductible
Routine Hearing Exams (Ages 21 and over)	100%	80% after deductible
Routine Mammogram (One per benefit period)	100%	80% after deductible
Routine Pap Test (One per benefit period)	100%	80% after deductible
Routine Laboratory, X-ray, and Medical Tests (All ages)	100%	80% after deductible
Routine Endoscopic Services	100%	80% after deductible
Routine Vision Exam includes refraction (Ages 21 and over)	100%	80% after deductible
Outpatient Services		
Surgical Services (other than a physician's office)	90% after deductible	80% after deductible
Diagnostic Services	90% after deductible	80% after deductible
Diagnostic Mammograms	$20 Copay, then 100%	80% after deductible
Physical and Occupational Therapies - Facility and Professional	90% after deductible	80% after deductible
Chiropractic Therapy – Professional Only	$20 Copay, then 100%	80% after deductible
Speech Therapy – Facility and Professional	90% after deductible	80% after deductible
Cardiac Rehabilitation	90% after deductible	80% after deductible
Emergency use of an Emergency Room	$100 Copay, then 100%	
Non-Emergency use of an Emergency Room	$100 Copay, then 90%	80% after deductible

Benefits	Network	Non-Network
Inpatient Facility		
Semi-Private Room and Board	90% after deductible	80% after deductible
Diagnostic Services	90% after deductible	80% after deductible
Professional Services	90% after deductible	80% after deductible
Semi-Private Room and Board	90% after deductible	80% after deductible
Skilled Nursing Facility (90 days per benefit period)	90% after deductible	80% after deductible
Inpatient Rehabilitation (60 days per benefit period)	90% after deductible	80% after deductible
Additional Services		
Ambulance	90% after deductible	80% after deductible
Durable Medical Equipment including Prosthetic Appliances and Orthotic Devices	90% after deductible	80% after deductible
Home Healthcare (90 visits per benefit period)	90% after deductible	80% after deductible
Hospice	90% after deductible	80% after deductible
Intrauterine Device (IUD)	90% after deductible	80% after deductible
Jobst/Elastic Stockings	90% after deductible	80% after deductible
Organ Transplants	90% after deductible	80% after deductible
Private Duty Nursing	90% after deductible	80% after deductible
Prosthetic Wig following chemotherapy(one per benefit period)	90% after deductible	80% after deductible
EXCLUDED SERVICES: Treatment of Benign Gynecomastia; Treatment of Hyperhidrosis	Not Covered	Not Covered
Mental Health and Substance Abuse – Federal Mental Health Parity		
Inpatient Mental Health and Substance Abuse Services	90% after deductible	80% after deductible
Outpatient Mental Health and Substance Abuse Services	90% after deductible	80% after deductible

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

Non-Contracting and Facility Other Providers will pay the same as Non-Network.

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.

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[1]Maximum family deductible. Member deductible is the same as single deductible.

[2]The office visit copay applies to the cost of the office visits only.

[3] 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.

[4]Failure to present an ID card may result in decreased benefits.

MEDICAL MUTUAL

Boardman Township Trustees
SuperMed® Script[1]
Prescription Drug Program
Proposed Rx
4-1-2011

Benefits	Copay	Day Supply
Benefit Period	January 1st through December 31st	
Dependent Age Limit	Same as Medical	
SuperMed Script Retail Program with Oral Contraceptive Coverage – for the initial filling and up to two refills of a prescription drug		
Generic Copayment	$15	30
Formulary Copayment	$25	30
Non-Formulary Copayment	$40	30
Diabetic Supplies[1]	$0	30
Asthmatic Supplies[3]	$0	30
SuperMed Script Retail Program with Oral Contraceptive Coverage – after the third retail fill of a prescription drug		
Generic Copayment	$30	30
Formulary Copayment	$50	30
Non-Formulary Copayment	$80	30
Diabetic Supplies[2]	$0	30
Asthmatic Supplies[3]	$0	30
SuperMed Script Mail Order Program with Oral Contraceptive Coverage		
Generic Copayment	$20	90
Formulary Copayment	$50	90
Non-Formulary Copayment	$75	90
Diabetic Supplies[2]	$0	90
Asthmatic Supplies[3]	$0	90

ADDITIONAL BENEFITS:
- Anorexiants

EXCLUSIONS:
- Medications for treatment of Onchomycosis (toenail fungus)

Note: Benefits will be determined based on Medical Mutual's medical and administrative policies and procedures.

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[1]Includes Rx Selections® Drug List: A list of drugs on the Rx Selections® formulary will be used.
[2]Includes over-the-counter items, as well as insulin, syringes and needles, glucose monitors and meters.
[3]Includes Replacement bags, Peak Flow Meters and Inhalation Spacers only.