Youngstown STATE UNIVERSITY

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 Must Select Primary Care Physician (PCP). Referrals are not needed to see in Network specialists.	Hospital & Physician 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 Non-Network- 25% Coinsurance until $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). Office Visit Co pays Do Not Count Toward Annual Maximum	In-Network $425 / $850 Non-Network $925 / $1,350	N/A $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 25% of Coinsurance After Deductible Non-Network	Covered in Full in Network Non Authorized Services; 80% Coinsurance after Deductible – Inpatient care 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 Non Authorized Services; 80% Coinsurance after Deductible – Inpatient care 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 1 per benefit period	Covered in Full 1 per benefit period	Covered in Full in Network 1 per benefit period
Mammography and Pelvic Exams, PAP Test, and PSA Test	Covered in Full 1 per benefit period	Covered in Full 1 per benefit period	Covered in Full in Network 1 per benefit period
Immunizations, Annual Diabetic Eye Exam	Covered in Full 1 per benefit period	Covered in Full 1 per benefit period	Covered in Full in Network 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 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 1 per benefit period	Exam given by Network ophthalmologist or optometrist covered in full. 1 per benefit period
Hearing Exams	Covered in Full 1 per benefit period	Covered in Full 1 per benefit period	Covered in Full in Network 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 [3]25 visit maximum combined for Physical/Occupational Therapy and Spinal Manipulation	Covered in full [3]25 visit maximum combined for Physical/Occupational Therapy and Spinal Manipulation	Covered in full in Network 12 visit maximum
OUTPATIENT SERVICES			
Surgical Services	In-Network; 15% Coinsurance after Deductible Non-Network; 25% Coinsurance after Deductible	Covered in Full in Network 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 Non-Network; 25% Coinsurance after Deductible	Covered in Full in Network Non Authorized Services; 80% Coinsurance after Deductible	Covered in Full in Network
Diagnostic Services	In-Network; 15% Coinsurance after Deductible Non-Network; 25% Coinsurance after Deductible	Covered in Full	Covered in Full in Network
Respiratory Therapy & Pulmonary Therapy	In-Network; 15% Coinsurance after Deductible Non-Network; 25% Coinsurance after Deductible	Covered in Full in Network Non Authorized Services; 80% Coinsurance after Deductible	Covered in Full in Network
Dialysis Treatments	In-Network; 15% Coinsurance after Deductible Non-Network; 25% Coinsurance after Deductible	Covered in Full in Network Non Authorized Services; 80% Coinsurance after Deductible	Covered in Full in Network
INPATIENT SERVICES			
Semi-Private Room and Board	Network, 15% Coinsurance after Deductible Non-network; 25% Coinsurance after Deductible	Covered in full in Network Non-network; 20% Coinsurance after Deductible	Covered in full in Network

Maternity Services	15% Coinsurance, after Deductible Non-network; 25% coinsurance after deductible	Covered in full in Network Non-network; 20% Coinsurance after Deductible	Covered in Full in Network
Home Care Services **(Care must be non-custodial in nature and can not be for convenience)**	In-Network; 15% Coinsurance after Deductible Non-Network; 25% Coinsurance after Deductible	Covered in Full in Network Non Authorized Services; 50%	Covered in Full in Network
Hospice Services	In-Network; 15% Coinsurance after Deductible Non-Network; 25% Coinsurance after Deductible	Covered in Full in Network Non Authorized Services; 50% Coinsurance after Deductible	Covered in Full in Network
Skilled Nursing Facility	In-Network; 15% Coinsurance after Deductible Non-Network; 25% Coinsurance after Deductible	Covered in full in Network 100 Days Per Benefit Period 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 **$1,000,000 per life time**	Covered in Full **$1,000,000 per life time**	Covered in full in Network **Unlimited**
Initial Newborn Exam — Physician	15% Coinsurance after Deductible	Covered in full in Network Non-network; 20% Coinsurance after Deductible	Covered in full in Network
Private Duty Nurse	15% Coinsurance after Deductible **$5,000 maximum per benefit period** **(Must demonstrate medical necessity)**	Covered in full in Network Non-network; 20% Coinsurance after Deductible **$5,000 maximum per benefit period** **(Must demonstrate medical necessity)**	Covered in full in Network **Only available in conjunction with Home Health Care**

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