MEDICAL MUTUAL

Mahoning County Commissioners
SuperMed Plus
Effective 1-1-2012

SuperMed Plus

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit Over Aged Child	26 28 Removal upon Birthdate	
Lifetime Maximum	$2,500,000	
Benefit Period Deductible – Single/Family	None	None
Coinsurance	100%	80%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	None	$1,500 / $3,000
Physician/Office Services		
Office Visit (Illness/Injury)[1]	$10 copay, then 100%	$10 copay, then 100%
All Immunizations	100%	80% after deductible
Preventative Services		
Routine Physical Exam (One per benefit period; ages eighteen and over)[1]	$10 copay, then 100%	80% after deductible
Routine Hearing Exam (One per benefit period)[1]	$10 copay, then 100%	80% after deductible
Well Child Care Services including Exam, Laboratory and Immunizations (To age eighteen)[1]	$10 copay, then 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 Lab, X-rays and Medical Tests (ages eighteen and over)	100%	80% after deductible
Routine Endoscopic Services	100%	80% after deductible
Outpatient Services		
Surgical Services	100%	80% after deductible
Diagnostic Services	100%	80% after deductible
Physical Therapy (40 visits per benefit period)	100%	80% after deductible
Occupational Therapy	100%	80% after deductible
Chiropractic Therapy (20 visits per benefit period)	100%	80% after deductible
Speech Therapy (30 visits per benefit period)	100%	80% after deductible
Cardiac Rehabilitation	100%	80% after deductible
Emergency use of an Emergency Room[2]	$50 copay, then 100%	
Non-Emergency use of an Emergency Room[2,3]	$50 copay, then 100%	$50 copay, then 80%

Benefits	Network	Non-Network
Inpatient Facility		
Semi-Private Room and Board	100%	80% after deductible
Maternity	100%	80% after deductible
Skilled Nursing Facility (100 days per benefit period)	100%	80% after deductible
Additional Services		
Allergy Testing and Treatments	100%	80% after deductible
Ambulance	100%	100%
Durable Medical Equipment	100%	80% after deductible
Home Healthcare (210 visits per benefit period)	100% for 1st 60 visits then 50% for remaining visits	50% after deductible
Hospice	100%	80% after deductible
Organ Transplants ($1,000,000 maximum per lifetime)	100%	80% after deductible
Private Duty Nursing ($5,000 maximum per benefit period)	100%	80% after deductible
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; limited to three admissions per lifetime for substance abuse)	100%	80% after deductible
Outpatient Mental Health and Substance Abuse Services (45 visits per benefit period)	$10 copay then 100%	Visits 1-10 $10 copay then 80%. Visits 11-45 $10 copay then 50%

Note: Services requiring a copayment are not subject to the single/family 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.

[1]The office visit copay applies to the cost of the office visit only.
[2]Copay waived if admitted.
[3]The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance.

MEDICAL MUTUAL

Mahoning County Commissioners
Prescription Drug Program
Effective 1-1-2012

Benefits	Copay	Day Supply
Benefit Period	January 1st through December 31st	
Dependent Age Limit Over Aged Child	26 28 Removal upon Birthdate	
Retail Program with Oral Contraceptive		
Generic Copayment	$10	30
Brand Name Copayment	$20	30
Brand Name for which no Generic is available	$20	30
Brand Name for which a Generic is available but you choose the Brand Name	$20 plus the difference between the cost of the Generic and Brand	30
Mail Order Program with Oral Contraceptive		
Generic Single Order Copayment	$15	90
Brand Single Order Copayment	$15	90
Brand Single Order for which no Generic is available	$15	90
Brand Single Order for which a Generic is available but you choose the Brand Name	$15 plus the difference between the cost of the Generic and Brand	90

Note: These benefits do include coverage for oral contraceptives

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MEDICAL MUTUAL

Mahoning County Commissioners
SuperMed Vision™ Plan E
EyeMed Access Network
Effective 01/01/12

SuperMed Vision™

Services	EyeMed Access Network	Non-Network[1]
Dependent Age Limit	26	
Over Aged Child	28 Removal upon Birthdate	
Professional Services (One every 12 months)		
Spectacle exam	$15 copayment	$15 maximum
Contact lens exam	$15 copayment + any amount over spectacle exam	$15 maximum
Frame (One every 12 months)	$0 copayment (Up to $120. 20% off anything more than $100)	$30 maximum
Lenses (Uncoated plastic. One pair every 12 months)		
Single vision	$15 copayment	$10 maximum
Bifocal	$15 copayment	$20 maximum
Trifocal	$15 copayment	$30 maximum
Lenticular	$15 copayment	$40 maximum
Contact Lenses (In lieu of lenses and frames. One pair every 12 months)		
Conventional	$15 copayment (up to $100)	$40 maximum
Medically necessary	$15 copayment (up to $200)	$75 maximum
Disposable	$15 copayment (up to $100)	$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
Progressive (no-line bifocal)	$65
Polycarbonate	$40
Scratch-resistant coating	$15
Ultraviolet coating	$15

Lens options	*Discounted price
Anti-reflective coating	$45
Solid tint or Gradient tint	$15
Photochromic	20% off retail price
Glass	20% off retail price

* Discounted price is in addition to the $15 copayment listed above. Discounts are 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 Contact Lens by Mail 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.

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