MEDICAL MUTUAL

City of Ravenna
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 End of Month	
Pre-Existing Condition Waiting Period (Does not apply to under the age of 19)	Initial Group Waived, All Others 3-3-12	
Blood Pint Deductible	2 pints	
Overall Annual Benefit Period Maximum	$2,000,000	
Benefit Period Deductible – Single/Family[1]	$100/$200	$500/$1,000
Coinsurance	90%	70%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	$500/$1,000	$1,500/$3,000
Physician/Office Services		
Office Visit (Illness/Injury)[2]	$15 copay, then 100%	70% after deductible
Urgent Care Office Visit[2]	$15 copay, then 100%	70% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	90% after deductible	70% after deductible
Allergy Testing/Treatment	90% after deductible	70% after deductible
Preventative Services		
Routine Physical Exams (One per benefit period; Age 21 and over)[2]	$15 copay, then 100%	70% after deductible
Well Child Care Services including Exam , Routine Vision, Routine Hearing Exams, Well Child Care Immunizations and Laboratory Tests (Birth To Age 21)[2]	$15 copay, then 100%	70% after deductible
Well Child Care Laboratory Tests (To Age 21)	100% Not subject to the deductible	70% after deductible
Routine Mammogram (One per benefit period)	90% Not subject to the deductible	70% after deductible
Routine Pap Test (One per benefit period)	90% Not subject to the deductible	70% after deductible
Routine Lab, X-Rays, and Tests	90% Not subject to the deductible	70% after deductible
Outpatient Services		
Surgical Services	90% after deductible	70% after deductible
Diagnostic Services	90% after deductible	70% after deductible
Physical and Occupational Therapy (10 visits, then Medical Review)	90% after deductible	70% after deductible
Speech Therapy (10 visits, then Medical Review)	90% after deductible	70% after deductible
Cardiac Rehabilitation	90% after deductible	70% after deductible
Supplemental Accident – first $500 paid 100%	90% after deductible	70% after deductible
Artificial Insemination	Not Covered	Not Covered

Benefits	Network	Non-Network
Outpatient Services		
Emergency use of an Emergency Room	90% after deductible	
Non-Emergency use of an Emergency Room	90% after deductible	70% after deductible
Inpatient Facility		
Semi-Private Room and Board	90% after deductible	70% after deductible
Maternity	90% after deductible	70% after deductible
Skilled Nursing Facility (365 days per benefit period)	90% after deductible	70% after deductible
Additional Services		
Ambulance	90% after deductible	70% after deductible
Durable Medical Equipment	90% after deductible	70% after deductible
Home Healthcare (100 visits per benefit period)	90% after deductible	70% after deductible
Hospice	90% after deductible	70% after deductible
Organ Transplants[3]	90% after deductible	70% after deductible
Private Duty Nursing	90% after deductible	70% after deductible
Mental Health and Substance Abuse — Federal Mental Health Parity		
Inpatient Mental Health and Substance Abuse Services	Benefits paid are based on corresponding medical benefits	
Outpatient Mental Health and Substance Abuse Services		

Note: Deductible expenses incurred for services by a network provider will only apply to the network deductible out-of-pocket limits. Deductible expenses incurred for services by a non-network provider will only apply to the non-network deductible out-of-pocket limits.

Coinsurance expenses incurred for services by a network provider will only apply to the network coinsurance out-of-pocket limits. Coinsurance expenses incurred for services by a non-network provider will only apply to the non-network coinsurance out-of-pocket limits.

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. 3-month carryover applies. Services requiring a copayment are not subject to the single/family deductible.

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

[3]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).

MEDICAL MUTUAL™

City of Ravenna
Prescription Drug Program[1]
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 End of Month	
Preferred Formulary Retail Program with Oral Contractives Coverage		
Generic Copayment	$5	34
Formulary Copayment	$10	34
Non-Formulary Copayment	$20	34
Preferred Formulary Mail Order Program with Oral Contraceptive Coverage		
Generic Copayment	$10	90
Formulary Copayment	$20	90
Non-Formulary Copayment	$40	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.

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[1] Preferred Formulary

MEDICAL MUTUAL

City of Ravenna
SuperMed Vision™ Plan I
EyeMed Access Network
Effective 1-1-2012

SuperMed Vision™

Services	EyeMed Access Network	Non-network[1]
Dependent Age Limit Over Aged Child	26 28 Removal upon End of Month	
Professional Services (One every 12 months) Spectacle exam Contact lens exam	$10 copayment $10 copayment + any amount over spectacle exam	$20 maximum $20 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	$0 copayment $0 copayment $0 copayment $0 copayment	$20 maximum $30 maximum $40 maximum $50 maximum
Contact lenses (instead of lenses and frames. One pair every 12 months) Conventional Medically necessary Disposable	$0 copayment (up to $100) $0 copayment (up to $100) $0 copayment (up to $100)	$65 maximum $65 maximum $65 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. 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

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. EyeMed Vision Care manages SuperMed Vision.

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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.

*Discounts available through EyeMed Access providers only.