



**Ohio Turnpike Commission
SuperMed Plus Plan B
Non-Bargaining and Bargaining
Effective 1-1-2011**



Benefits	Network	Non-Network
Benefit Period	January 1 st through December 31 st	
Dependent Age Limit	26	
Over Aged Child	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	0 pints	
Overall Annual Benefit Period Maximum	\$1,250,000	
Benefit Period Deductible – Single/Family ¹	\$300 / \$600	
Coinsurance	80%	60%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	\$1,200 / \$2,400	\$2,700 / \$5,400
Physician/Office Services		
Office Visit (Illness/Injury) ²	\$15 copay, then 100%	60% after deductible
Urgent Care Facility Services ²	\$15 copay, then 100%	60% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	80% after deductible	60% after deductible
Preventative Services		
Routine Physical Exam ²	\$15 copay, then 100%	60% after deductible
Well Child Care Services including Exam and Immunizations (To Age 21) ²	\$15 copay, then 100%	60% after deductible
Well Child Care Laboratory Tests (To Age 21)	100%	60% after deductible
Routine Mammogram (One per benefit period)	100%	60% after deductible
Routine Pap Test (One per benefit period)	100%	60% after deductible
Routine Colonoscopy	100%	60% after deductible
Routine Prostate Specific Antigen (PSA) Test and Blood Occult Screening	100%	60% after deductible
Routine Cholesterol	100%	60% after deductible
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel and Urinalysis (one each per benefit period)	100%	60% after deductible
Routine Immunizations – In addition to the Immunizations covered under Physician/Office Services above, the following Routine Immunizations are covered for members from birth to age 23: Measles/Mumps/Rubella (MMR); Measles/Rubella; Measles; Mumps; Rubella	100%	60% after deductible
Outpatient Services		
Surgical Services	80% after deductible	60% after deductible
Diagnostic Lab, X-Ray, and EKG Services	100%	60% after deductible
Physical/Occupational Therapy - Facility and Professional (40 visits per benefit period)	80% after deductible	60% after deductible
Chiropractic Therapy – Professional Only (12 visits per benefit period)	80% after deductible	60% after deductible
Speech Therapy – Facility and Professional (20 visits per benefit period)	80% after deductible	60% after deductible
Cardiac Rehabilitation	80% after deductible	60% after deductible
Emergency use of an Emergency Room ^{3,4}	\$100 copay, then 100%	
Non-Emergency use of an Emergency Room ^{3,4}	\$100 copay, then 80%	\$100 copay, then 60%

Benefits	Network	Non-Network
Inpatient Facility		
Semi-Private Room and Board	80% after deductible	60% after deductible
Maternity	80% after deductible	60% after deductible
Skilled Nursing Facility	80% after deductible	60% after deductible
Additional Services		
Allergy Testing and Treatments	80% after deductible	60% after deductible
Ambulance	100%	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Home Healthcare	80% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible
Organ Transplants	80% after deductible	60% after deductible
Private Duty Nursing	80% after deductible	60% 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: Services requiring a copayment are not subject to the single/family deductible.

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

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

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

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.

¹Maximum family deductible. Member deductible is the same as single deductible. 3 month carryover applies.

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

³Copay waived if admitted.

⁴The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance.