



**Lake Erie Regional Council  
SuperMed Plus  
Plan 1**



Benefits	Network	Non-Network
Benefit Period	January 1 <sup>st</sup> through December 31 <sup>st</sup>	
Dependent Age Limit	19 Dependent / 23 Student Removal upon End of Month	
Pre-Existing Condition Waiting Period	Initial Group Waived, All Others 3-3-12	
Blood Pint Deductible	0 pints	
Lifetime Maximum	Unlimited	
Benefit Period Deductible – Single / Family <sup>1</sup>	\$250 / \$500	\$500 / \$1,000
Coinsurance	90%	70%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single / Family	\$1,000 / \$2,000	\$2,000 / \$4,000
<b>Physician/Office Services</b>		
Office Visit (Illness/Injury) <sup>2</sup>	\$15 copay, then 100%	70% after deductible
Urgent Care Office Visit <sup>2</sup>	\$15 copay, then 100%	70% after deductible
Immunizations (Tetanus Toxoid, HPV Vaccine, Rabies Vaccine, Influenza, VSV, Hepatitis B, MMR, Pneumococcal Polysaccharide and Meningococcal Polysaccharide Vaccine are covered services)	90% after deductible	70% after deductible
<b>Preventative Services</b>		
Routine Physical Exams (Ages nine and over)	100%	50% after deductible
Well Child Care Services including Exam and Immunizations (To age one, limited to a \$500 maximum; Ages one to nine, limited to a \$150 maximum per birth year)	100%	50% after deductible
Well Child Care Laboratory Tests (To age nine)	100%	50% after deductible
Routine Mammogram (One per benefit period)	100%	50% after deductible
Routine Gynecological Exam associated with Pap Test (One per benefit period)	100%	50% after deductible
Routine Pap Test (One per benefit period)	100%	50% after deductible
Routine Prostate Specific Antigen (PSA)	100%	50% after deductible
Routine Labs, X-rays and Medical Tests	100%	50% after deductible
Routine Endoscopic Services	100%	50% after deductible
<b>Outpatient Services</b>		
Surgical Services	90% after deductible	70% after deductible
Diagnostic Services	90% after deductible	70% after deductible
Physical, Occupational and Chiropractic Therapy - Facility and Professional (10 visits then Medical Review )	90% after deductible	70% after deductible
Speech Therapy – Facility and Professional (Unlimited)	90% after deductible	70% after deductible
Cardiac Rehabilitation	90% after deductible	70% after deductible
Emergency use of an Emergency Room <sup>3</sup>	\$50 copay, then 100%	
Non-Emergency use of an Emergency Room <sup>4</sup>	\$50 copay, then 80%	70% after deductible

<b>Benefits</b>	<b>Network</b>	<b>Non-Network</b>
<b>Inpatient Facility</b>		
Semi-Private Room and Board	90% after deductible	70% after deductible
Maternity	90% after deductible	70% after deductible
Skilled Nursing Facility	90% after deductible	70% after deductible
<b>Additional Services</b>		
Wigs After Chemotherapy	90% after deductible	70% after deductible
Allergy Testing (one per benefit period)	90% after deductible	70% after deductible
Allergy Treatments	90% after deductible	70% after deductible
Ambulance	90% after deductible	70% after deductible
Durable Medical Equipment	90% after deductible	70% after deductible
Home Healthcare (40 visits per benefit period)	90% after deductible	70% after deductible
Hospice	90% after deductible	70% after deductible
Organ Transplants	90% after deductible	70% after deductible
Private Duty Nursing	90% after deductible	70% after deductible
TMJ Devices	Not Covered	Not Covered
<b>Mental Health and Substance Abuse</b>		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period)	90% after deductible	70% after deductible
Outpatient Mental Health and Substance Abuse Services (30 visits per benefit period)	90% after deductible	70% after deductible

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

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.

Filing Limit – Two Years

<sup>1</sup>Maximum family deductible. Member deductible is the same as single deductible. 3-month carryover applies.

<sup>2</sup>The office visit copay applies to the cost of the office visit only.

<sup>3</sup>Copay waived if admitted. The copay applies to room charges only. All other covered charges are not subject to deductible.

<sup>4</sup>Copay waived if admitted. The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance