Baldwin Wallace College
SuperMed Plus
January 1, 2012

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit **Older Age Child**	**26** **28** Removal upon Birth Date	
Pre-Existing Condition Waiting Period	Does not apply	
Blood Pint Deductible	0 pints	
Annual Maximum	$2,500,000	
Benefit Period Deductible – Single/Family[1]	$650/$1,300	$650/$1,300
Coinsurance	80%	70%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	$600/$1,200	$1,500/$3,000
Physician/Office Services		
Office Visit (Illness/Injury) [2]	$15 Copay, then 100%	70% after deductible
Urgent Care Office Visits[2]	$25 Copay, then 100%	70% after deductible
All Immunizations	80% after deductible	70% after deductible
Allergy Testing and Treatments	80% after deductible	70% after deductible
Preventative Services		
Preventive Services, in accordance with state and federal law[3]	100% - NO DEDUCTIBLE	70% after deductible
Office Visit/Routine Physical Exam (Age 21 and over)	100% - NO DEDUCTIBLE	70% after deductible
Well Child Care Services including Exam , Routine Vision, Routine Hearing Exams, Well Child Care Immunizations and Laboratory Tests (To age 21)	100% - NO DEDUCTIBLE	70% after deductible
Routine Mammogram (One per benefit period)	100% - NO DEDUCTIBLE	70% after deductible
Routine Pap Test (One per benefit period)	100% - NO DEDUCTIBLE	70% after deductible
All Routine Labs, X-rays and Diagnostic Medicals	Routine – 100% No Deductible / Diagnostic – 80% after deductible	70% after deductible
Routine Endoscopic Services	100% NO DEDUCTIBLE	70% after deductible
Routine Bone Density Screening	100% NO DEDUCTIBLE	70% after deductible
Outpatient Services		
Surgical Services	80% after deductible	70% after deductible
Physical, Occupational, Chiropractic Therapy (20 visits per benefit period)	$15 Copay, then 100%	70% after deductible
Speech Therapy – Facility and Professional (10 visits per benefit period)	$15 Copay, then 100%	70% after deductible
Cardiac Rehabilitation	80% after deductible	70% after deductible
Emergency use of an Emergency Room[4]	$200 copay, then 100%	
Non-Emergency use of an Emergency Room[5]	$300 copay, then 100%	

Inpatient Facility		
Semi-Private Room and Board	80% after deductible	70% after deductible
Ancillary Services	80% after deductible	70% after deductible
Maternity	80% after deductible	70% after deductible
Skilled Nursing Facility (100 days per benefit	80% after deductible	70% after deductible

period)		
Additional Services		
Ambulance	$25 Copay, then 100%	70% after deductible
Durable Medical Equipment	80% after deductible	70% after deductible
Diabetic Education and Training	80% after deductible	70% after deductible
Home Healthcare	80% after deductible	70% after deductible
Hospice	80% after deductible	70% after deductible
Organ Transplants (1 organ per lifetime)	80% after deductible	70% after deductible
Private Duty Nursing	80% after deductible	70% after deductible
Mental Health and Substance Abuse Services – 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 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.

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

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]Maximum family deductible. Member deductible is the same as single deductible.
[2]The office visit copay applies to the cost of the office visit only.
[3]Preventive services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.
[4]Copay waived if admitted. The copay applies to room charges only. All other covered charges are not subject to deductible.
[5]Copay waived if admitted. The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance.