Garfield Heights Board of Education
SuperMed Plus
Effective 1/1/2011
687072 – 461

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Older Aged Child	26 26 Removal upon Birth Date	
Pre-Existing Condition Waiting Period (does not apply to members under the age of 19)	Initial Group Waived, 3-3-12	
Blood Pint Deductible	2 pints	
Overall Annual Benefit Period Maximum	Unlimited	
Benefit Period Deductible – Single/Family[1]	None	$200 / $400
Coinsurance	100%	80%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	None	$1,000 / $2,000
Physician/Office Services		
Office Visit (Illness/Injury)	100%	80% after deductible
Urgent Care Office Visit	100%	80% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	100%	80% after deductible
Preventative Services		
Routine Physical Exam (Ages 21 and over, one exam per benefit period)	100%	50% after deductible
Well Child Care Services including Exam, Routine Vision, Routine Hearing Exams, Well Child Care Immunizations and Laboratory Tests (31 visits per Lifetime; Birth to age 21)	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 EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period)	100%	50% after deductible
Outpatient Services		
Surgical Services	100%	80% after deductible
Diagnostic Services	100%	80% after deductible
Physical/Occupational/Chiropractic Therapy – Facility and Professional (20 visits per benefit period)	100%	80% after deductible
Cardiac Rehabilitation	100%	80% after deductible
Speech Therapy – Facility and Professional (10 visits per benefit period)	100%	80% after deductible
Emergency use of an Emergency Room[2]	$50 copay, then 100%	
Non-Emergency use of an Emergency Room[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%	80% after deductible
Durable Medical Equipment	100%	80% after deductible
Home Healthcare	100%	80% after deductible
Hospice	100%	80% after deductible
Organ Transplants	100%	80% after deductible
Private Duty Nursing	100%	80% 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.

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.

[1]Maximum family deductible. Member deductible is the same as single deductible. 3-month carryover applies.
[2]Copay waived if admitted. The copay applies to room charges only. All other covered charges are not subject to deductible.
[3]Copay waived if admitted. The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance.

RETAIL AND HOME DELIVERY PRESCRIPTION DRUG SCHEDULE OF BENEFITS

Benefit Period	Calendar Year
Dependent Age Limit	Please refer to your medical Schedule of Benefits
Days Supply	30 days for retail Prescription Drugs or 90 days for Home Delivery Prescription Drugs
Benefits provided under this Prescription Drug coverage will accumulate towards the medical Benefit Period Maximum.	

COPAYMENTS FOR RETAIL PRESCRIPTION DRUG COVERED SERVICES		
TYPE OF SERVICE	**For Prescription Drug Covered Services received from a Participating Drug Provider**[1]	**For Prescription Drug Covered Services received from a Non-Participating Drug Provider**[1]
	YOU PAY THE FOLLOWING	
Generic Prescription Drugs	$10 Copayment	$10 Copayment
Brand Name Formulary Prescription Drugs	$20 Copayment	$20 Copayment
Brand Name Non-Formulary Prescription Drugs	$40 Copayment	$40 Copayment

COPAYMENTS FOR HOME DELIVERY PRESCRIPTION DRUG COVERED SERVICES		
TYPE OF SERVICE	**For Prescription Drug Covered Services received from a Contracting Home Delivery Pharmacy**[1]	**For Prescription Drug Services received from a Non-Contracting Home Delivery Pharmacy**
	YOU PAY THE FOLLOWING	
Generic Prescription Drugs	$20 Copayment	Not Covered [2]
Brand Name Formulary Prescription Drugs	$40 Copayment	Not Covered [2]
Brand Name Non-Formulary Prescription Drugs	$80 Copayment	Not Covered [2]

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[1] Please refer to the Prescription Drug Benefits section for additional information.
[2] Benefits for Prescription Drugs are available when obtained from a retail Pharmacy.

Garfield Heights Board of Education
Traditional Dental
With Orthodontia

Benefits	
Benefit Period	January 1st through December 31st
Dependent Age Limit	23; Removal upon Birth Date
Benefit Period Maximum (per member)	$2,500
Benefit Period Deductible (per member)[1]	$50
Orthodontic Lifetime Maximum (per eligible dependent up to age 19)	$1,500
Preventive Services	
Oral Exams – two per benefit period	100%
Bite Wing X-Rays – two sets per benefit period	100%
Prophylaxis (cleaning) – two per benefit period	100%
Fluoride Treatment – one treatment per benefit period, limited to dependents up to age 19	100%
Space Maintainers- limited to eligible dependents up to age 19	100%
Diagnostic X-Rays – including Full Mouth/Panorex, which are limited to one every 36 consecutive months	100%
Caries Susceptibility Test	100%
Essential Services	
Consultations and Other Exams by Specialist	80% after deductible
Minor Restorative Services	80% after deductible
Endodontics/Pulp Services	80% after deductible
Periodontal Services	80% after deductible
Repairs, Relines & Adjustments of Prosthetics	80% after deductible
Simple Extractions	80% after deductible
Impactions	80% after deductible
Minor Oral Surgery Services	80% after deductible
General Anesthesia	80% after deductible
Complex Services	
Gold Foil Restoration	80% after deductible
Inlays, Onlays – one every five years	80% after deductible
Crowns – one every five years	80% after deductible
Bridgework (Pontics & Abutments) – one every five years	80% after deductible
Partial and Complete Dentures – one every five years	80% after deductible

Benefits	
Orthodontic Services	
Orthodontic Diagnostic Services	60%
Minor Treatment for Tooth Guidance	60%
Minor Treatment for Harmful Habits	60%
Interceptive Orthodontic Treatment	60%
Comprehensive Orthodontic Treatment	60%

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

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Using the Dentmax network can reduce your the out of pocket amount.

[1]Maximum deductible per member. 3-month carryover applies.

Garfield Heights Board of Education
Vision

Benefits	
Benefit Period	January 1st through December 31st
Dependent Age Limit	Same as Medical
Examinations	**One per Calendar Year**
Vision Examinations	100% of Traditional Amount
Frames	**One per Calendar Year**
Basic Frames	100% of Traditional Amount Per Frame
Prescription Lenses	**One pair per Calendar Year**
Single Vision Lenses	100% of Traditional Amount per pair
Bifocal Lenses	100% of Traditional Amount per pair
Trifocal Lenses	100% of Traditional Amount per pair
Lenticular Single Lenses	100% of Traditional Amount per pair
Lenticular Bifocal Lenses	100% of Traditional Amount per pair
Lenticular Trifocal Lenses	100% of Traditional Amount per pair
Contacts In Lieu of Lenses	**One per Calendar Year**
Medically Necessary	100% of Traditional Amount per pair
Cosmetic (Contacts are provided in lieu of lenses and frames)	$75 per pair

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

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