



SUPERMED ONE®



SHORT-TERM PERSONAL HEALTH INSURANCE
FOR INDIVIDUALS UNDER 65



SHORT-TERM PERSONAL HEALTH INSURANCE





SUPERMED ONE[®]

SHORT-TERM PERSONAL HEALTH INSURANCE
from Medical Mutual of Ohio[®]

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SUPERMED ONE[®] SHORT-TERM PERSONAL HEALTH INSURANCE PROVIDES YOU WITH THE PROTECTION YOU NEED FROM CATASTROPHIC AND UNEXPECTED HEALTHCARE EMERGENCIES. SUPERMED ONE SHORT-TERM PLANS FROM MEDICAL MUTUAL OF OHIO[®] PROVIDE COVERAGE FOR SIX MONTHS AND GIVE YOU THE SECURITY OF A COMPREHENSIVE HEALTH PLAN FROM A NAME YOU KNOW AND TRUST.

SuperMed One short-term coverage is designed for an individual who is:

- Between jobs.
- Waiting for an employer's group coverage to begin.
- An early retiree.
- A temporary or seasonal employee.
- A student or recent graduate.
- A laid-off, striking or terminating employee.

FEATURES AND BENEFITS

- A simple and fast enrollment process
- Protection from the expense of catastrophic and unexpected illness
- Access to the largest network of doctors, hospitals and healthcare professionals in Ohio – no referrals required
- \$25 office visit copays
- Prescription drug coverage
- Multiple deductible options from \$250 to \$1,500 for individuals and \$500 to \$3,000 for families
- Covered benefits for network services at 80% after your deductible is met
- Online access to your claims, benefits and a provider directory
- Flexible payment options

NETWORKS

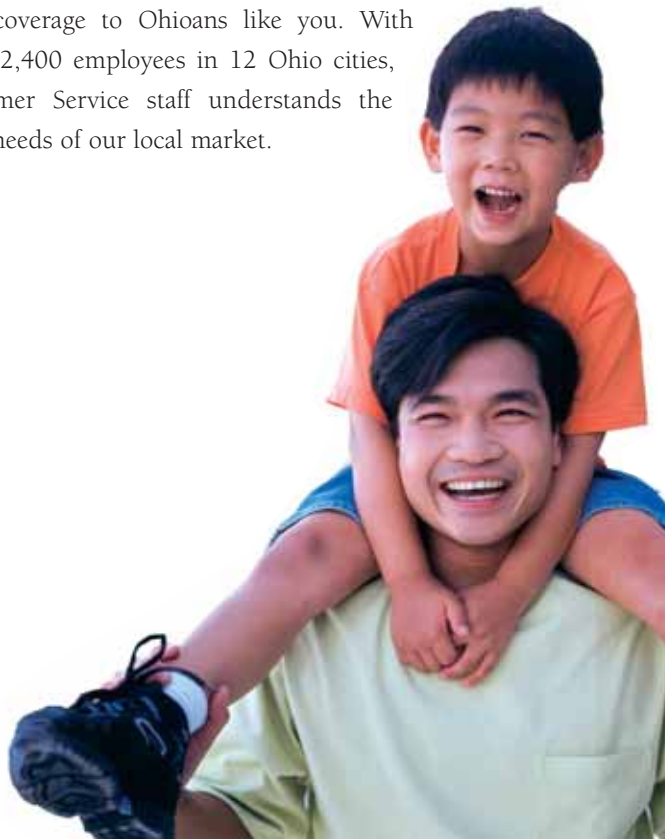
Medical Mutual makes it easy to find trusted physicians and hospitals. Our preferred provider network, SuperMed Plus®, offers access to the largest networks of hospitals, physicians and healthcare professionals in Ohio, giving you the flexibility to select healthcare professionals who are right for you. You may also self-refer to any specialist who is in the network – there is no need to get a referral from your doctor. Contact your broker or agent for a network provider directory, or visit MedMutual.com for an updated list of in-network healthcare professionals.

PRE-EXISTING CONDITIONS

Pre-existing conditions are not covered for the entire term of the short-term plan. A pre-existing condition is a condition for which an ordinarily prudent person would seek medical advice, diagnosis, care or treatment, or for which you incurred medical expenses, received medical treatment, used a prescription drug or were advised by a physician to receive treatment during the 24 months prior to your effective date.

ABOUT MEDICAL MUTUAL OF OHIO

Since 1934, Medical Mutual has been providing health insurance coverage to Ohioans like you. With more than 2,400 employees in 12 Ohio cities, our Customer Service staff understands the healthcare needs of our local market.



MEDICAL MUTUAL ONLINE

MedMutual.com was developed to help bring you the information you need when you need it. Our goal is to provide as many features as possible to our members via the Internet. Internet functions are available 24 hours a day, seven days a week.

You can link to *My Health Plan*, our member information site, from MedMutual.com or SuperMedOne.com, where you can:

- Review benefits and claims information.
- Update personal contact information.
- Request a new ID card or certificate booklet.
- Appeal a claim.
- E-mail a Customer Service representative.
- Locate a network doctor.
- Access prescription drug information from *Medco*, Medical Mutual's pharmaceutical benefit manager.

Additional features available online include access to:

- Medical Mutual's *SuperWell® Health Management Programs*.
- *WebMD®*, the premier consumer health information resource and Medical Mutual partner, provides a broad spectrum of medical information, advice and interactive Web-based tools.
- Health and fitness club discounts through *GlobalFit*.

SHORT-TERM BENEFITS

BENEFITS

Benefit Period	Six months beginning with enrollment date
Dependent Age Limit	19 Dependent, 23 Student, Removal upon end of month
Lifetime Maximum	\$2,500,000

	NETWORK	NON-NETWORK
Benefit Period Deductible (\$250/\$500 plan) – Single/Family	\$250/\$500	\$500/\$1,000
Benefit Period Deductible (\$500/\$1,000 plan) – Single/Family	\$500/\$1,000	\$1,000/\$2,000
Benefit Period Deductible (\$1,000/\$2,000 plan) – Single/Family	\$1,000/\$2,000	\$2,000/\$4,000
Benefit Period Deductible (\$1,500/\$3,000 plan) – Single/Family	\$1,500/\$3,000	\$3,000/\$6,000
Coinsurance – Single/Family	80%	50%
Coinsurance Out-of-Pocket Maximum – Single/Family	\$5,000/\$10,000	\$10,000/\$20,000

MEDICAL SERVICES

PHYSICIAN/OFFICE SERVICES

Medically Necessary Office Visits	\$25 copay per visit, then 100%	\$25 copay per visit, then 50%
Urgent Care Office Visit	\$25 copay per visit, then 100%	\$25 copay per visit, then 50%
Immunizations (tetanus toxoid, rabies and meningococcal polysaccharide vaccines)	80% after deductible	50% after deductible ¹
Well-Child Care Services (to age nine) ²	80% after deductible	50% after deductible
Routine Pap Test – One per benefit period	80% after deductible	50% after deductible
Routine Mammogram – One per benefit period	80% after deductible	50% after deductible

OUTPATIENT SERVICES

Allergy Testing and Treatments	80% after deductible	50% after deductible ¹
Diagnostic Services	80% after deductible	50% after deductible
Surgery	80% after deductible	50% after deductible
Physical and Occupational Therapy, Speech Therapy and Chiropractic Services (10 visits each per benefit period)	80% after deductible	50% after deductible
Cardiac Rehabilitation	80% after deductible	50% after deductible
Emergency Use of a Hospital Emergency Room ³	\$100 copay, then 80% after deductible	
Non-Emergency Use of a Hospital Emergency Room ³	\$100 copay then 80% after deductible	\$100 copay, then 50% after deductible

INPATIENT FACILITY

Semi-Private Room and Board	80% after deductible	50% after deductible
Skilled Nursing Facility (\$10,000 maximum per benefit period)	80% after deductible	50% after deductible

ADDITIONAL SERVICES

Ambulance Service (\$2,500 maximum per benefit period)	\$100 copay, then 80%	\$100 copay, then 80%
Durable Medical Equipment	80% after deductible	50% after deductible
Home Healthcare (60 visits per benefit period)	80% after deductible	50% after deductible ¹
Hospice	80% after deductible	50% after deductible ¹
Organ and Tissue Transplants ⁴	80% after deductible	50% after deductible
Value Vision ⁵	Discount	None

SUBSTANCE ABUSE

Inpatient Alcoholism (30 days per benefit period)	80% after deductible	50% after deductible ¹
Outpatient Alcoholism (20 visits per benefit period)	50% after deductible ¹	50% after deductible ¹

PRESCRIPTION DRUG – ORAL CONTRACEPTIVES INCLUDED

Prescription Drug Benefit Period Deductible – Single/Family	\$250/\$500
Benefit Period Maximum	\$500
Retail – 30-day supply	80% after deductible
Home Delivery	Not Covered

¹ Coinsurance does not apply to coinsurance out-of-pocket maximums. These services will not be covered at 100% once coinsurance out-of-pocket maximums are met.

² Well-child exams and well-child immunizations are limited to \$500 per child to age one; thereafter, \$150 per child per birth year to age nine.

³ Copay waived if admitted.

⁴ 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). Failure to contact Care Management prior to the proposed course of treatment (including the evaluation) will result in a \$5,000 penalty. There will be a \$10,000 non-network penalty for failure to use a SuperMed facility or a Non-Designated Organ Transplant Network provider. This penalty may be waived by the Case Manager if the proper pre-determination procedures are followed.

⁵ A separate Value Vision discount program highlight sheet is available. If SuperMed Vision is purchased, Value Vision will be removed from the base benefit.

SHORT-TERM BENEFIT EXCLUSIONS AND LIMITATIONS

SuperMed One short-term medical coverage is not provided for services and supplies:

- Incurred before the policy effective date.
- Incurred after the policy termination date.
- For experimental or investigation of drugs, devices, medical treatments or procedures.
- That are not medically necessary.
- To the extent governmental units or their agencies provide benefits.
- For a condition that occurs as a result of any act of war.
- Received from a member of your immediate family.
- For which payment was made or would have been made under Medicare Parts A or B if benefits were claimed.
- Received in a military facility for a military service-related condition.
- For surgery and other services primarily to improve appearance or to treat a mental or emotional condition through a change in body form.
- For treatment of a condition related to an autistic disease of childhood, learning disabilities, hyperkinetic syndromes, behavioral problems or mental retardation, except as specified.
- For arch supports and other foot care or foot support devices used only to improve comfort or appearance, which include but are not limited to care of flatfeet, subluxations, corns, bunions, calluses and toenails.
- For treatment for weight loss, by methods such as prescription drugs, dietary supplements, vitamins and any care which is primarily dieting or exercise or for weight loss through surgery. This includes complications resulting from weight loss surgery or such other methods as may be recognized by the National Institutes of Health.
- For marital counseling.
- For the medical treatment of sexual problems not caused by a biological disease.
- For transsexual surgery or any treatment leading to, or in connection with transsexual surgery.
- For birth control devices which include but are not limited to IUDs and diaphragms.
- For reverse sterilization.
- For artificial insemination or in vitro fertilization.
- For hypnosis and acupuncture.
- For fraudulent or misrepresented claims.

Please consult your *Certificate of Coverage* for a complete listing of benefits and exclusions. You may cancel your certificate within 10 days of having it in your possession and Medical Mutual will refund any premium paid.

NOTES ON SHORT-TERM BENEFITS LISTED ON PAGE 3:

Deductible expenses incurred for services by a network doctor or hospital will only apply to the network deductible. Deductible expenses incurred for services by a non-network doctor or hospital will only apply to the non-network deductible.

Coinsurance expenses incurred for services by a PPO network doctor or hospital will only apply to the PPO network coinsurance out-of-pocket. Coinsurance expenses incurred for services by a non-PPO network doctor or hospital will only apply to the non-PPO network coinsurance out-of-pocket.

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, verbally, 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. However, the covered person's coinsurance will always be based on the lesser of the healthcare professional's billed charges or Medical Mutual's negotiated rates with the healthcare professional.

ELIGIBILITY FOR SUPERMED ONE BENEFITS

You and your dependents may apply for SuperMed One insurance as long as you are:

- A resident of Ohio at least six months of the year
- Not eligible for or entitled to Medicare or Medicaid
- Under age 65
- Not pregnant or an expectant parent prior to or including the effective date of your SuperMed One policy

Family coverage includes you, your spouse and any unmarried children under the age of 19, or 23 for full-time students. Dependent-only coverage is also available.

Please note: Short-term medical coverage is non-renewable. You may re-apply for the short-term plan 90 days after the plan has been canceled or expired. For continuous coverage, apply for one of our standard, renewable SuperMed One personal health plans.

SHORT TERM APPLICATION/CHANGE FORM — OHIO

INSTRUCTIONS: All questions must be answered. Incomplete applications will be returned.

Section I: Contract Holder Information

Last Name		MI	First Name		Social Security Number	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed					Marriage Date: / /	Divorce Date: / /
Permanent Residence			City		E-mail Address	
County	State	Zip Code	Best Contact # ()		Alternate # ()	
Reason for Application: <input type="checkbox"/> Applying for new coverage <input type="checkbox"/> Applying for dependent-only coverage <input type="checkbox"/> Applying for change to current coverage						

LIST BELOW ALL INDIVIDUALS TO BE COVERED

	First Name, MI (and last name, if different)	Social Security Number	Birth Date	Sex	Height	Weight	Tobacco User	Student
Self							<input type="checkbox"/> Y <input type="checkbox"/> N	
Spouse							<input type="checkbox"/> Y <input type="checkbox"/> N	
1							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
2							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
3							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Section II: Federal and Ohio Open Enrollment Eligibility

1. Yes No Are you a **Federally Eligible Individual** or applying for coverage under the **Ohio Open Enrollment** requirements?

If Yes, **STOP HERE.** SuperMed One® is NOT a Federally Eligible or Ohio Open Enrollment product. For an information and application packet, please call Medical Mutual at 800/242-1936. SuperMed One may affect your status as a federally eligible individual. Visit the ohioinsurance.gov web site for more information.

Section III: Coverage Options

Requested Effective date: ___ / ___ / ___

SuperMed One Short Term:
Deductible Single/Family

- \$250/\$500 \$500/\$1,000
 \$1,000/\$2,000 \$1,500/\$3,000

Section IV: OTHER COVERAGE INFORMATION

Yes No Does **ANY PERSON TO BE COVERED** have any other type of health insurance (Accident, Medicare, Medicaid, etc.) or is **ANY PERSON TO BE COVERED** currently applying for any other health insurance? If yes, please complete the following:

NAME	TYPE	NAME OF INSURANCE COMPANY

WARNING: Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)

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Section V: MEDICAL ELIGIBILITY QUESTIONS

1. Are YOU, YOUR SPOUSE or any DEPENDENT currently pregnant, an expectant parent, or in the process of adoption (even if not named on this application)? **YES** **NO**
2. Is ANY PERSON TO BE COVERED currently hospitalized or in a nursing home? **YES** **NO**
3. Has any insurance company refused coverage to ANY PERSON TO BE COVERED? **YES** **NO**
If yes, please explain _____
4. Within the last 12 months have YOU or ANY PERSON TO BE COVERED taken any prescription medications? **YES** **NO**
If yes, please list all medications* _____
5. Within the last five years, have YOU or ANY PERSON TO BE COVERED received any medical or surgical consultation, advice, or treatment for any chronic illness including: heart or circulatory system disorders; neurological disorders; respiratory disorders; immune system disorders, including Acquired Immune Deficiency Syndrome (AIDS); cancer or tumor; diabetes; alcoholism or alcohol abuse; drug abuse or chemical dependency? **YES** **NO**
If yes, please provide details (include dates of treatment)* _____

*If more space is required please attach additional sheets.

Section VI: BILLING INFORMATION

- CHOOSE ONE:**
- HOME – Receive monthly premium billings**
 - FINANCIAL INSTITUTION – Have monthly automatic premium withdrawals**
 - CREDIT CARD – Have monthly premium billed to credit card**
 - DIFFERENT BILLING ADDRESS – Have home billing sent to a different address**

If you wish to be billed through your financial institution, please complete the following authorization:

I authorize Medical Mutual of Ohio to initiate premium deductions from my account. The authorization will remain in effect until Medical Mutual of Ohio and my financial institution have received written notification from me within a reasonable time period to allow termination of the deduction.

Premiums are to be deducted from: Checking Savings (Please note: Not all financial institutions allow deductions from a savings account. Please verify this information with your financial institution.) (Deducted on the first business day of the month)

Name and branch of bank/financial institution			Account Number
Address			Account Holder's Name
City	State	Zip	Transit Routing Number
Account Holder's Signature			Date

Please attach a voided check for checking account or a deposit slip for savings account for verification of bank information.

If you wish to be billed through your credit card, please complete the following authorization:

- Mastercard Visa (Deducted on 2nd business day of the month)

Cardholder Name	Card Number
Bank Name (if applicable)	Expiration Date
Account Holder's Signature	Date

If your permanent address is different than your billing address, complete the following:

Last Name (C/O)	First Name	MI
Address		
City	State	Zip

Section VII: HOW DID YOU HEAR ABOUT SUPERMED ONE? (CHECK ONE)

- 1. Friend/family member
- 2. Yellow Pages
- 3. Insurance Agent
- 4. Advertisement in newspaper, magazine, etc.
- 5. Newspaper article
- 6. Internet/Web site
- 7. Radio
- 8. Mail
- 9. Through current employer
- 10. Other _____

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ATTACH VOIDED CHECK OR DEPOSIT SLIP HERE

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Section VIII: TERMS AND CONDITIONS

I hereby apply under Medical Mutual of Ohio's Group Trust for the coverage indicated on this application. I further agree to participate in such trust and agree to be bound to the relevant terms of the Master Group Contract(s) and the Trust Agreement.

1. I authorize release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, the Medical Information Bureau Inc. (MIB), government agency or person to Medical Mutual of Ohio (MMO) and/or any affiliates or division of MMO: (a) to evaluate this application; (b) to adjudicate claims submitted on behalf of me or my dependents; (c) for utilization review programs to monitor health services or quality improvement activities and/or; (d) for credentialing purposes. I authorize MMO to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two and one-half years for the purpose of collecting information regarding this Application.
2. I agree that a medical examination of me may be required in connection with this Health Insurance Application. I further agree that I, as the Applicant, will be responsible to pay for the medical examination and/or the release of any and all records on behalf of myself, my spouse, and/or the listed dependents.
3. By signing below, I represent and warrant as follows: (a) I have thoroughly read and understand this Health Application and the questions asked herein; (b) I have answered each and every question set forth in this Application; (c) all of my answers to each of the questions are accurate, complete and true and (d) I did not sign a blank or partially completed Application. I agree that MMO, in its sole discretion, may rescind my policy at any time on the basis of any untrue, inaccurate or incomplete answer to any question in this Application, or any misrepresentation, omission or concealment on this Application, whether intentional or otherwise. I further agree that if a policy is issued, it will be issued by MMO in full reliance and in consideration of the information, answers and statements contained herein. I understand that this policy will be medically underwritten.
4. I have read the sales materials and understand the plan benefits, exclusions, and limitations as outlined therein. I acknowledge that the managed care features of this health insurance policy (such as the preferred provider organization network) have been explained to my satisfaction. I also understand that I may review a copy of the Master Group Contract(s) and Trust Agreement upon making such a written request to MMO.
5. No issuance, waiver, modification or change of policy or any of MMO rules or amendments shall be binding upon MMO unless it is in writing and signed by an authorized officer of MMO, as applicable.
6. Notice: Certain Pre-Existing Condition limitations will apply.
7. I represent that neither I nor my spouse are receiving any form of reimbursement or compensation for this coverage from any employer.
8. I understand that information submitted with this application may require further medical underwriting. If that underwriting discloses additional medical risk I understand that there may be a significant change in the rate charged for this coverage, or in certain cases the coverage may be rescinded. A permanent ID card will be issued following the final review and acceptance of the application.
9. I understand and agree that I am solely and exclusively responsible for the truth, accuracy and completeness of all of the answers contained in this application. I understand and agree that no agent or broker who may be assisting in the completion of this application has any authority (a) to waive any answer or any portion of any answer to any question on this application or any information MMO requests, (b) to advise me that I am not obligated to disclose any condition of which I am aware concerning my health or the health of any dependent included on the application, (c) to make any representation concerning health benefits that are inconsistent with, or different from, any written information provided by MMO or (d) to bind MMO in any way by making any statement, promise or representation that is not set out in writing in this application or regarding eligibility, benefits or issuance of a policy, (e) to answer any questions in, or insert any information on, this Application on my behalf, or (f) to approve coverage.
10. I understand and agree that I am responsible for disclosing all information required by this application, including but not limited to all health conditions and diagnoses of which I am aware. I understand and agree that MMO has the exclusive right to determine whether a particular condition or diagnosis is significant, that I do not have the right to evaluate whether a condition or diagnosis should or should not be disclosed on this application and that I am obligated to disclose even those conditions or diagnoses that I do not believe are significant or important.
11. My dependents and I understand and agree that any information obtained will not be released by the Company to any person or organization except to reinsuring companies, the MIB, or other persons or organizations performing healthcare operations or business or legal services in connection with any application, claim, or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of two and one-half years. I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and send my written revocation to MMO's Privacy Office. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my application, a claim or a pending insurance action. The revocation will become effective after it is received by MMO's Privacy Office.
12. I understand and agree that no agent or broker has the authority (1) to bind Medical Mutual by making promises regarding eligibility, benefits or issuance of a policy; (2) to waive any answer or any portion of any answer to any question on this application or any information Medical Mutual requests; (3) approve coverage; (4) make or alter any contract on behalf of Medical Mutual or (5) waive or alter any of Medical Mutual's other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of Medical Mutual to be binding on Medical Mutual.

I am signing this Health Application on my own behalf and on behalf of all listed dependents. An unaltered copy of this authorization is as valid as the original. I understand that I should not cancel any current health insurance coverage until I receive an approval letter and insurance policy from MMO.

Contract Holder's or Guardian's Signature

Date

Guardian's Social Security Number (if child-only policy)

Spouse's Signature

Date

Dependent's Signature if 18 or older

Date

Dependent's Signature if 18 or older

Date

Dependent's Signature if 18 or older

Date

FOR OFFICE USE ONLY

Agent of Record	Tax I.D.
Royal Advantage® Broker	Commission Indicator

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INSERT BUSINESS CARD



SHORT-TERM COVERAGE