City of Parma

Request For Proposal

Specifications for:
Medical, Prescription Drug,
Dental & Vision

Effective January 1, 2008

Prepared by:
The Fedeli Group

City of Parma
Healthcare Plans

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Introduction

The City of Parma is a well respected community located just outside Cleveland, Ohio. City Hall resides in the heart of Parma with several safety, service and community facilities throughout the City.

Background

The City of Parma has maintained a partially self-insured contract over the past several years. The group currently uses Medical Mutual of Ohio as their administrator, re-insurer and network for medical and dental benefits and Medco Health for prescription drug benefits. In addition, Kaiser is offered as an option for medical benefits. The group currently offers several options with hourly and salaried employees enjoying different plan designs based on departments and hire dates.

Objectives

The City of Parma's goal is to enhance the health status of their employees and families by providing quality benefits. The medical program should promote and support the best of traditional medical practices. In addition, the program should be easy to understand, address the diverse needs of the workforce and be affordable to all.

Specifically, the City of Parma's goals for their medical plan include:

- Encouraging wellness through the use of preventive care.
- Providing choice and flexibility for a diverse workforce in diverse business units.
- Designing a medical plan that is simple for employees to understand and use.
- Encouraging use of local providers and facilities.
- Maintaining the trust between patients and providers of care.
- Partnering with a managed care organization that can help manage the health of the employees and dependents today, and will work with the City to develop innovative new approaches to health care delivery in the future.

Objectives (Cont.)

- Securing the most favorable financial arrangement possible. While administrative fees and stop loss premiums should be competitive, the City is also interested in achieving favorable network financial discounts for its employees.

Key Selection Criteria

The successful vendor will be expected to meet the City of Parma's objectives (stated previously) and provide the following:

- Smooth administration of the proposed plan design, including pharmacy benefit management.
- Exceptional reporting capabilities *including* the ability to track and report utilization and cost data by each location.
- Competitive pricing based on group demographics and negotiated discounts.
- Superior customer service to the City of Parma and superior member service to employees.
- Internet (Web) based administration, allowing real time plan sponsor access to additions, deletions, status changes and claim information retrieval.
- Disease Management intervention and comprehensive wellness programs.

All questions concerning the bid specifications and the information contained in this document should be directed to the following:

Michael S. McGrath
The Fedeli Group
Crown Centre Building
5005 Rockside Road
Fifth Floor, Suite #500
Independence, OH 44131
(216) 328-8080

Section 1

Request for Proposal
The Fedeli Group
Crown Centre – Fifth Floor
P.O. Box 318003
Cleveland, Ohio 44131-8003
Today's Date: 8/23/07

Due Date: 09/15/07
Producer: Harry Brownfield **Phone:** (216) 328-8080 **Fax:** (216) 328-8081

All Proposals to show The Fedeli Group as Presenter

Client Name:	**City of Parma**
Client Address: County:	6611 Ridge Road Parma, OH 44129 Cuyahoga
SIC Code: Business Pursuit:	 **Municipality**
Current Carrier: Current Benefits Design: Current Rates: Single Family	**Medical Mutual** (See Attached) **Medical Mutual** See Attached ***Please quote both Fully Insured & Self Funded***
# Full Time Employees: # Employees Participating: Employee Contribution %:	 Per Union Contract – 10% on Average
Effective Date Requested:	**1/1/08**
Coverages Requested:	**X** Medical **X** Rx **X** Dental* **X** Vision* **Quote with Medical and separate from Medical*
Medical Plan to be Quoted: Plan 1: Plan 2:	 Duplicate the current plans. Duplicate current; however, replace Medical Plan #7 with the attached Core & Buy-Up dual option
Funding Options: Option 1: Option 2: Option 3: Commission:	 Fully-Insured Self-Funded $150,000 Specific (Medical & Rx) 12/15 Contract 125% Aggregate Corridor (Medical & Rx) Self-Funded $200,000 Specific (Medical &Rx) 12/15 Contract 125% Aggregate Corridor (Medical & Rx) 2% of Fully Insured Equivalent

Buy Up Plan

	In Network	Non Network
Deductible	$ 0	$ 100/200
Coinsurance	100%	80%
Out of Pocket Max	N/A	$3,000/$6,000
Office Visits	$15.00 copay then 100%	Deductible, 80%
Emergency Room	$75.00	$75.00
Urgent Care	$35.00	Deductible, 80%
PT/OT	$10copay	Deductible, 80%
	Must have Medical Review after 10 visits	
Add Routine Colonoscopy, Endoscopy, Sigmoidoscopy and PSA		
Prescription Drug	Retail: $10/$20/$30 Mail Order $20/$40/$60	

Core Plan

	In Network	Non Network
Deductible	$350/$700	$700/$1,400
Coinsurance	90%	70%
Out of Pocket Max	$1,300/$2,600	$2,600/$5,200
Office Visits	Deductible then 90%	Deduct, 70%
Emergency Room	$100.00	$100.00
Urgent Care	$35.00	Deduct, 70%
PT/OT	Deductible then 90%	Deduct, 70%
	Must have Medical Review after 10 visits	
Add Routine Colonoscopy, Endoscopy, Sigmoidoscopy and PSA		
Prescription Drug	Retail: $10/$20/$30 Mail Order $20/$40/$60	

Request for Proposal
The Fedeli Group
Crown Centre – Fifth Floor
P.O. Box 318003
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All Proposals to show The Fedeli Group as Presenter

Client Name:	**City of Parma**
Client Address: County:	6611 Ridge Road Parma, OH 44129 Cuyahoga
SIC Code: Business Pursuit:	 **Municipality**
Current Carrier: Current Benefits Design: Current Rates:	**Medical Mutual** (See Attached) See Attached
# Full Time Employees: # Employees Participating: Employee Contribution %:	 Per Union Contract – 10% on Average
Effective Date Requested:	**1/1/08**
Coverages Requested:	**X** Rx
Rx Plan to be Quoted: Current Option	 Duplicate the current plans. In addition to the current plans please quote additional option of: Retail: $10/$20/$30 and MOD: 20/$40/$60
Funding Options: Option 1: Option 2: Commission:	 Fully-Insured Self-Funded/ASO 2% of Fully Insured Equivalent

Request for Proposal
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Crown Centre – Fifth Floor
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All Proposals to show The Fedeli Group as Presenter

Client Name:	**City of Parma**
Client Address: County:	6611 Ridge Road Parma, OH 44129 Cuyahoga
SIC Code: Business Pursuit:	 **Municipality**
Current Carrier: Current Benefits Design: Current Rates: Administration	**Medical Mutual** (See Attached) $2.03 Note: Dental is not covered under stop loss.
# Full Time Employees: # Employees Participating: Employee Contribution %:	 Per Union Contract – 10% on Average
Effective Date Requested:	**1/1/08**
Coverages Requested:	**X** Dental
Dental Plan to be Quoted: Plan 1:	 Duplicate the current plans.
Funding Options: Option 1: Option 2: Commission:	 Fully-Insured Self-Funded/ASO 2% of Fully Insured Equivalent

Request for Proposal
The Fedeli Group
Crown Centre – Fifth Floor
P.O. Box 318003
Cleveland, Ohio 44131-8003
Today's Date: 8/22/07

Due Date: 09/15/07
Producer: Harry Brownfield **Phone:** (216) 328-8080 **Fax:** (216) 328-8081

All Proposals to show The Fedeli Group as Presenter

Client Name:	**City of Parma**
Client Address: County:	6611 Ridge Road Parma, OH 44129 Cuyahoga
SIC Code: Business Pursuit:	 **Municipality**
Current Carrier: Current Benefits Design: Rates: Administration Stop Loss	**Union Eye Care** (See Attached) Current / Renewal $4.07 / $4.90 $14.31 / $15.68
# Full Time Employees: # Employees Participating: Employee Contribution %:	 Per Union Contract – 10% on Average
Effective Date Requested:	**1/1/08**
Coverages Requested:	**X** Vision
Rx Plan to be Quoted: Plan 1:	 Duplicate the current plan.
Funding Options: Option 1: Commission:	 Fully-Insured Net of commission

Notes:
Quoting carriers will need to co-exist with Union Eye Care as union-negotiated contracts dictate that the union plans can not switch to another carrier for the following Sections: 105, 106, 115, 116, 121, 122, 305, 306, 315, 316, 321, 322 (approximately 100 employees).

Section 2

a.

CITY OF PARMA - STRUCTURE TRANSITION AS OF 8/1/07			
DESCRIPTION	**SECTION**	**BENEFIT**	**DESCRIPTION**
Fire	103	SMP, RX, SuperDental	Medical Option 7 & Rx Option 5
Fire	104	SMP, RX, Direct Reimbursement Dental	Medical Option 7 & Rx Option 5
Service	105	SMP, RX, SuperDental	Medical & Rx Option 1
Service	106	SMP, RX, Direct Reimbursement Dental	Medical & Rx Option 1
Service Supervisors	115	SMP, RX, SuperDental	Medical & Rx Option 1
Service Supervisors	116	SMP, RX, Direct Reimbursement Dental	Medical & Rx Option 1
Record Room	121	SMP, RX, SuperDental	Medical & Rx Option 1
Record Room	122	SMP, RX, Direct Reimbursement Dental	Medical & Rx Option 1
Public Official - New Benefits	125	SMP, RX, SuperDental	Medical & Rx Option 1
Public Official - New Benefits	126	SMP, RX, Direct Reimbursement Dental	Medical & Rx Option 1
Public Official - Old Benefits	127	SMP, RX, SuperDental	Medical & Rx Option 2
Public Official - Old Benefits	128	SMP, RX, Direct Reimbursement Dental	Medical & Rx Option 2
Retirees with FT Students	132	SMP, RX	Medical & Rx Option 1
Old Retirees	133	Cost Logic (SuperDental)	Manual
Old Retirees	134	MMO (Direct Reimbursement Dental)	Manual
Retirees SuperDental	137	SuperDental	
Retirees Direct Reimbursement	138	Direct Reimbursement Dental	
Cobra	140	SMP, RX	Medical & Rx Option 1
Cobra	141	SMP, RX, SuperDental	Medical & Rx Option 1
Cobra	142	SMP, RX, Direct Reimbursement Dental	Medical & Rx Option 1
Kaiser - Cobra	143	SuperDental	
Kaiser - Cobra	144	Direct Reimbursement Dental	
Kaiser	145	SuperDental	
Kaiser	146	Direct Reimbursement Dental	
Prisoners	200	SMP, RX	
Service	305	Traditional, RX, SuperDental	Medical 3 - Rx Option 4
Service	306	Traditional, RX, Direct Reimbursement Dental	Medical 3 - Rx Option 4
Service Supervisors	315	SMP, RX, SuperDental	Medical & Rx Option 4
Service Supervisors	316	SMP, RX, Direct Reimbursement Dental	Medical & Rx Option 4
Record Room	321	SMP, RX, SuperDental	Medical & Rx Option 4
Record Room	322	SMP, RX, Direct Reimbursement Dental	Medical & Rx Option 4
Cobra	340	SMP, RX	Medical & Rx Option 4
Cobra	341	SMP, RX, SuperDental	Medical & Rx Option 4
Cobra	342	SMP, RX, Direct Reimbursement Dental	Medical & Rx Option 4
COBRA	351	SMP, RX, SuperDental	Medical Option 7 & Rx Option 5
COBRA	352	SMP, Rx, Trad Dental	Medical Option 7 & Rx Option 5
COBRA	353	SMP, Rx ONLY	Medical Option 7 & Rx Option 5
Schedule A	401	SMP, RX, SuperDental	Medical Option 7 & Rx Option 5
Schedule A	402	SMP, RX, Direct Reimbursement Dental	Medical Option 7 & Rx Option 5
Police	501	SMP, RX, SuperDental	Medical Option 7 & Rx Option 5
Police	502	SMP, RX, Direct Reimbursement Dental	Medical Option 7 & Rx Option 5
Dispatcher	503	SMP, RX, SuperDental	Medical Option 7 & Rx Option 5
Dispatcher	504	SMP, RX, Direct Reimbursement Dental	Medical Option 7 & Rx Option 5
Police Supervisors	505	SMP, RX, SuperDental	Medical Option 7 & Rx Option 5
Police Supervisors	506	SMP, RX, Direct Reimbursement Dental	Medical Option 7 & Rx Option 5
Correction Officers	507	SMP, RX, SuperDental	Medical Option 7 & Rx Option 5
Correction Officers	508	SMP, RX, Direct Reimbursement Dental	Medical Option 7 & Rx Option 5
Schedule A Court	509	SMP,Rx, SuperDental	Medical Option 7 & Rx Option 5
Schedule A Court	510	SMP, RX, Direct Reimbursement Dental	Medical Option 7 & Rx Option 5
AFSCME	511	SMP, RX, SuperDental	Medical Option 7 & Rx Option 5
AFSCME	512	SMP, RX, Direct Reimbursement Dental	Medical Option 7 & Rx Option 5

Medical Option 1 - SMP - $10 OV copay
Medical Option 2 - SMP - $5 OV copay
Medical Option 3 - Traditional - New Hires 2004
Medical Option 4 - SMP - New Hires effective 01/01/04 (Deductible)
Medical Option 5 - SMP - $10 OV copay - Firemen only - Routine Testing
Medical Option 7 - $200/$400 PPO Plan
RX Option 1 - $15 Brand / $10 Single Source / $5 Generic with $10/$5 mandatory mail order
RX Option 2 - $5 Brand / $0 Generic with $10 / $5 mail order
RX Option 3 - $15 Brand / $10 Single Source / $5 Generic with $10/$5 mail order
RX Option 4 - $10 Brand / $5 Generic with $10/$5 mandatory mail order - New Hires effective 01/01/04
Rx Option 5 - $10/Generic, $20/Formulary & $30/Non Formulary mandatory MOD - $25 Generic, $50/Form & $75 Non Form

Current/Active
Medical Plan Designs

Medical Mutual

Effective 1/1/03

City of Parma
SuperMed Plus
Option 1

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birth Date	
Lifetime Maximum	$2,500,000	
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)[2]	$10 copay, then 100%	80% after deductible
Urgent Care Facility Services[2]	$10 copay, then 100%	80% after deductible
Voluntary Second Surgical Opinion	100%	80% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	100%	Not Covered
Preventative Services		
Office Visit/Routine Physical Exams[2]	$10 copay, then 100%	Not Covered
Well Child Care Exams (To age eighteen)[2]	$10 copay, then 100%	Not Covered
Well Child Care Immunizations (To age eighteen)	100%	Not Covered
Well Child Care Laboratory Tests (To age eighteen)	100%	
Routine Mammogram (One, limited to an $85 maximum per benefit period)	100%	
Routine Pap Test	100%	
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis	100%	
Outpatient Services		
Surgical Services	100%	80% after deductible
Diagnostic Services	100%	
Physical and Occupational Therapy – Facility and Professional (10 visits then Medical Review)	100%	80% after deductible
Chiropractic Therapy – Professional Only (Unlimited)	$10 copay, then 100%	80% after deductible
Speech Therapy – Facility and Professional (10 visits then Medical Review)	100%	80% after deductible
Cardiac Rehabilitation	100%	80% after deductible
Emergency use of an Emergency Room	100%	
Non-Emergency use of an Emergency Room[3,4]	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%	Not Covered
Ambulance	100%	80% after deductible
Durable Medical Equipment	100%	80% after deductible
Education and Training	100%	Not Covered
Family Planning	100%	Not Covered
Home Healthcare	100%	Not Covered
Hospice	100%	Not Covered
Organ Transplants	100%	80% after deductible
Private Duty Nursing	100%	80% after deductible
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period, three admissions per lifetime)	100%	Not Covered
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	$10 copay, then 100%	50%[5] after deductible

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

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

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]Copay waived if admitted
[4]The copay applies to room charges only All other covered charges are subject to deductible and coinsurance
[5]Not applied to Coinsurance Out-of-Pocket Maximum

Efective 1/1/03

City of Parma
SuperMed Plus
Option 2

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birth Date	
Lifetime Maximum	$2,500,000	
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)[2]	$5 copay, then 100%	80% after deductible
Urgent Care Facility Services[2]	$5 copay, then 100%	80% after deductible
Voluntary Second Surgical Opinion	100%	80% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	100%	Not Covered
Preventative Services		
Office Visit/Routine Physical Exams[2]	$5 copay, then 100%	Not Covered
Well Child Care Exams (To age eighteen)[2]	$5 copay, then 100%	Not Covered
Well Child Care Immunizations (To age eighteen)	100%	Not Covered
Well Child Care Laboratory Tests (To age eighteen)	100%	
Routine Mammogram (One, limited to an $85 maximum per benefit period)	100%	
Routine Pap Test	100%	
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis	100%	
Outpatient Services		
Surgical Services	100%	80% after deductible
Diagnostic Services	100%	
Physical and Occupational Therapy – Facility and Professional (10 visits then Medical Review)	100%	80% after deductible
Chiropractic Therapy – Professional Only (Unlimited)	$5 copay, then 100%	80% after deductible
Speech Therapy – Facility and Professional (10 visits then Medical Review)	100%	80% after deductible
Cardiac Rehabilitation	100%	80% after deductible
Emergency use of an Emergency Room	100%	
Non-Emergency use of an Emergency Room[3 4]	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%	Not Covered
Ambulance	100%	80% after deductible
Durable Medical Equipment	100%	80% after deductible
Education and Training	100%	Not Covered
Family Planning	100%	Not Covered
Home Healthcare	100%	Not Covered
Hospice	100%	Not Covered
Organ Transplants	100%	80% after deductible
Private Duty Nursing	100%	80% after deductible
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period, three admissions per lifetime)	100%	Not Covered
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	$5 copay, then 100%	50%[5] after deductible

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

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

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]Copay waived if admitted
[4]The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance
[5]Not applied to Coinsurance Out-of-Pocket Maximum

Effective 1/1/04

City of Parma
Traditional
New Hires Effective 01/01/04
Medical Plan 3

Benefits	
Benefit Period	January 1st through December 31st
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birth Date
Pre-Existing Condition Waiting Period	Not Subject to Pre-Ex
Blood Pint Deductible	0 pints
Lifetime Maximum	$2,500,000
Benefit Period Deductible – Single/Family[1]	$200 / $400
Coinsurance	80%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	$1,000 / $2,000
Physician/Office Services	
Office Visit (Illness/Injury)	80% after deductible
Urgent Care Office Visit	80% after deductible
Voluntary Second Surgical Opinion	80% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	80% after deductible
Preventative Services	
Office Visit/Routine Physical Exam (One exam per benefit period)	80% after deductible
Well Child Care Services including Exam and Immunizations (To age nine)	80% after deductible
Well Child Care Laboratory Tests (To age nine)	100%
Routine Mammogram (One, limited to an $85 maximum per benefit period)	100%
Routine Pap Test (One per benefit period)	100%
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis	100%
Outpatient Services	
Surgical Services	80% after deductible
Diagnostic Services	100%
Physical and Occupational Therapy - Facility and Professional (10 visits then Medical Review)	80% after deductible
Chiropractic Therapy – Professional Only (Unlimited)	80% after deductible
Speech Therapy – Facility and Professional (10 visits then Medical Review)	80% after deductible
Cardiac Rehabilitation	80% after deductible
Emergency use of an Emergency Room[2]	$50 copay, then 100%
Non-Emergency use of an Emergency Room[2,3]	$50 copay, then 80%

Benefits	
Inpatient Facility	
Semi-Private Room and Board	80% after deductible
Maternity	80% after deductible
Skilled Nursing Facility (100 days per benefit period)	80% after deductible
Additional Services	
Allergy Testing and Treatments	80% after deductible
Ambulance	80% after deductible
Durable Medical Equipment	80% after deductible
Home Healthcare	80% after deductible
Hospice	80% after deductible
Organ Transplants	80% after deductible
Private Duty Nursing	80% after deductible
Mental Health and Substance Abuse	
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period)	50% after deductible
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	50% after deductible

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

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

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
[3]The copay applies to room charges only All other covered charges are subject to deductible and coinsurance

Effective 1/1/04

City of Parma
SuperMed Plus
New Hires Effective 01/01/04
Medical Plan 4

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birth Date	
Pre-Existing Condition Waiting Period	Not Subject to Pre-Ex	
Blood Pint Deductible	0 pints	
Lifetime Maximum	$2,500,000	
Benefit Period Deductible – Single/Family[1]	$200 / $400	
Coinsurance	80%	70%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	$1,000 / $2,000	$1,500 / $3,000
Physician/Office Services		
Office Visit (Illness/Injury)	80% after deductible	70% after deductible
Urgent Care Office Visit	80% after deductible	70% after deductible
Voluntary Second Surgical Opinion	80% after deductible	70% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	80% after deductible	Not Covered
Preventative Services		
Office Visit/Routine Physical Exam (One exam per benefit period)	80% after deductible	Not Covered
Well Child Care Services including Exam and Immunizations (To age nine)	80% after deductible	Not Covered
Well Child Care Laboratory Tests (To age nine)	100%	
Routine Mammogram (One, limited to an $85 maximum per benefit period)	100%	
Routine Pap Test (One per benefit period)	100%	
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis	100%	
Outpatient Services		
Surgical Services	80% after deductible	70% after deductible
Diagnostic Services	100%	
Physical and Occupational Therapy – Facility and Professional (10 visits then Medical Review)	80% after deductible	70% after deductible
Chiropractic Therapy – Professional Only (Unlimited)	80% after deductible	70% after deductible
Speech Therapy – Facility and Professional (10 visits then Medical Review)	80% after deductible	70% after deductible
Cardiac Rehabilitation	80% after deductible	70% after deductible
Emergency use of an Emergency Room[2]	$50 copay, then 100%	
Non-Emergency use of an Emergency Room[2 3]	$50 copay, then 80%	$50 copay, then 70%

Benefits	Network	Non-Network
Inpatient Facility		
Semi-Private Room and Board	80% after deductible	70% after deductible
Maternity	80% after deductible	70% after deductible
Skilled Nursing Facility (100 days per benefit period)	80% after deductible	70% after deductible
Additional Services		
Allergy Testing and Treatments	80% after deductible	Not Covered
Ambulance	80% after deductible	70% after deductible
Durable Medical Equipment	80% after deductible	70% after deductible
Home Healthcare	80% after deductible	Not Covered
Hospice	80% after deductible	Not Covered
Organ Transplants	80% after deductible	70% after deductible
Private Duty Nursing	80% after deductible	70% after deductible
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period)	50% after deductible	Not Covered
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	50% after deductible	50%[4] after deductible

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

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 Contracting.

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]Copay waived if admitted
[3]The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance
[4]Not applied to Coinsurance Out-of-Pocket Maximum

Medical Plan #7

City of Parma
SuperMed Plus
$200/$400 Deductible Plan
Effective 1-1-2007

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birth Date	
Pre-Existing Condition Waiting Period	Not Subject to Pre-Ex	
Blood Pint Deductible	0 pints	
Lifetime Maximum	$2,500,000	
Benefit Period Deductible – Single/Family[1]	$200 / $400	$400 / $800
Coinsurance	90%	70%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	$1,000 / $2,000	$2,000 / $4,000
Physician/Office Services		
Office Visit (Illness/Injury)	90% after deductible	70% after deductible
Urgent Care Office Visit	90% after deductible	70% after deductible
Voluntary Second Surgical Opinion	90% after deductible	70% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	90% after deductible	Not Covered
Preventative Services		
Office Visit/Routine Physical Exam (One exam per benefit period)	90% after deductible	Not Covered
Well Child Care Services including Exam and Immunizations (To age eighteen)	90% after deductible	Not Covered
Well Child Care Laboratory Tests (To age eighteen)	100%	
Routine Mammogram (One per benefit period)	100%	
Routine Pap Test (One per benefit period)	100%	
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis	100%	
Outpatient Services		
Surgical Services	90% after deductible	70% after deductible
Diagnostic Services	100%	
Physical and Occupational Therapy – Facility and Professional (10 visits then Medical Review)	90% after deductible	70% after deductible
Chiropractic Therapy – Professional Only (Unlimited)	90% after deductible	70% after deductible
Speech Therapy – Facility and Professional (10 visits then Medical Review)	90% after deductible	70% after deductible
Cardiac Rehabilitation	90% after deductible	70% after deductible
Emergency use of an Emergency Room[2]	$50 copay, then 100%	
Non-Emergency use of an Emergency Room[2,3]	$50 copay, then 90%	$50 copay, then 70%

Benefits	Network	Non-Network
Inpatient Facility		
Semi-Private Room and Board	90% after deductible	70% after deductible
Maternity	90% after deductible	70% after deductible
Skilled Nursing Facility (100 days per benefit period)	90% after deductible	70% after deductible
Additional Services		
Allergy Testing and Treatments	90% after deductible	Inpatient 70% after deductible Outpatient Not Covered
Ambulance	90% after deductible	70% after deductible
Durable Medical Equipment	90% after deductible	70% after deductible
Home Healthcare	90% after deductible	Not Covered
Hospice	90% after deductible	Not Covered
Organ Transplants	90% after deductible	70% after deductible
Private Duty Nursing	90% after deductible	70% after deductible
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period)	50%[4] after deductible	Not Covered
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	50%[4] after deductible	50%[4] after deductible

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

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 Contracting.

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]Copay waived if admitted.
[3]The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance
[4]Not applied to Coinsurance Out-of-Pocket Maximum.

Kaiser Permanente HMO

Rate Listing
for CITY OF PARMA - 0102
RENEWAL
Rates Effective 1/1/2007 - 12/31/2007

OUTPATIENT CARE	
Office Visits including:	
•Exams, allergy testing, well-child care, hearing tests	$10 per visit
•Allergy treatment	No Charge
•Outpatient surgery	$10 per visit
•Specialty care	$10 per visit
•Vision Exams available through affiliated providers	$10 per visit
Prenatal Care	No Charge
Urgent Care	
•At Kaiser Permanente facilities or outside the service area	$10 per visit
Physical, Speech, and Occupational Therapy	$10 per visit
•Up to 2 months or 30 visits per therapy, whichever is greater, per medical episode	
DIAGNOSTIC SERVICES	
•Laboratory and diagnostic testing, X-rays	No Charge
HOSPITAL INPATIENT CARE	
No annual or lifetime limit on covered days, including:	No Charge
•Physician and surgeon services; Room and board, anesthesia, operating and recovery rooms; Laboratory and diagnostic testing, x-rays	
EMERGENCY SERVICES (Fee waived if admitted)	
Emergency Services provided at a Plan Facility	$10 per visit
Emergency Services provided at a non-Plan Facility	$10 per visit
AMBULANCE SERVICES	
Only when transportation in any other vehicle would endanger your health	No Charge
MENTAL HEALTH SERVICES	
Inpatient - 30 days of hospital care per calendar year	No Charge
Outpatient - 20 visit maximum	
•Individual Therapy	$10 per visit
•Group Therapy(each visit counts as one-half visit against maximum)	$5 per visit
CHEMICAL DEPENDENCY SERVICES	
Inpatient	
•Detoxification in a general hospital	No Charge
•Detoxification in a specialized facility--1 admit per year	No Charge
Outpatient	
•Detoxification	$10 per visit
•Individual Therapy	$10 per visit
•Group Therapy	$5 per day
ALTERNATE CARE	
Home Health Services	No Charge
Hospice Home Care/Respite Care	No Charge
Skilled care in a Skilled Nursing Facility	No Charge
•Up to 100 days per calendar year	
INFERTILITY SERVICES	
•Inpatient	30%*
•Outpatient	30%
PRESCRIPTION DRUGS	

•Covered Formulary Drugs and Accessories up to a 31 day supply at Kaiser Permanente and affiliated network facilities	$5 copay
•Up to 62 day supply of maintenance drugs by mail order from the Kaiser Permanente Mail Order Pharmacy	
DURABLE MEDICAL EQUIPMENT	
Coverage limited to specific durable medical equipment	No Charge

*When a plan deductible is indicated, inpatient infertility services are subject to deductible.

Notes and Restrictions

- The benefits listed above are only a summary Detailed benefit information and exclusions are available on request

b.

Structure Prior to 8/1/07

CITY OF PARMA - 716636 TRANSITION			
DESCRIPTION	SECTION	BENEFIT	DESCRIPTION
Police	101	SMP, RX, SuperDental	CLOSED 8/1/2006
Police	102	SMP, RX, Direct Reimbursement Dental	CLOSED 8/1/2006
Fire	103	SMP, RX, SuperDental	Med Option 5 & Rx Option 1
Fire	104	SMP, RX, Direct Reimbursement Dental	Med Option 5 & Rx Option 1
Service	105	SMP, RX, SuperDental	Med & Rx Option 1
Service	106	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
AFSCME	107	SMP, RX, SuperDental	CLOSED 8/1/2007
AFSCME	108	SMP, RX, Direct Reimbursement Dental	CLOSED 8/1/2007
Dispatcher	109	SMP, RX, SuperDental	CLOSED 9/1/2006
Dispatcher	110	SMP, RX, Direct Reimbursement Dental	CLOSED 9/1/2006
Schedule A	111	SMP, RX, SuperDental	CLOSED 5/1/2006
Schedule A	112	SMP, RX, Direct Reimbursement Dental	CLOSED 5/1/2006
Police Supervisors	113	SMP, RX, SuperDental	CLOSED 9/1/2006
Police Supervisors	114	SMP, RX, Direct Reimbursement Dental	CLOSED 9/1/2006
Service Supervisors	115	SMP, RX, SuperDental	Med & Rx Option 1
Service Supervisors	116	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
Schedule A Court	117	SMP, RX, SuperDental	CLOSED 8/1/2007
Schedule A Court	118	SMP, RX, Direct Reimbursement Dental	CLOSED 8/1/2007
PT Assistant Law Directors	119	SMP, RX, SuperDental	Med & Rx Option 1
PT Assistant Law Directors	120	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
Record Room	121	SMP, RX, SuperDental	Med & Rx Option 1
Record Room	122	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
Correction Officers	123	SMP, RX, SuperDental	CLOSED 9/1/2006
Correction Officers	124	SMP, RX, Direct Reimbursement Dental	CLOSED 9/1/2006
Public Official - New Benefits	125	SMP, RX, SuperDental	Med & Rx Option 1
Public Official - New Benefits	126	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
Public Official - Old Benefits	127	SMP, RX, SuperDental	Med & Rx Option 2
Public Official - Old Benefits	128	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 2
Employee Senior Dependents	129	SMP, RX, SuperDental	CLOSED 08/01/2007
Employee Senior Dependents	130	SMP, RX, Direct Reimbursement Dental	CLOSED 08/01/2007
Close	131		
Retirees with FT Students	132	SMP, RX	Med & Rx Option 1
Old Retirees	133	Cost Logic (SuperDental)	Manual
Old Retirees	134	MMO (Direct Reimbursement Dental)	Manual
Close	135		
Close	136		
Retirees SuperDental	137	SuperDental	
Retirees Direct Reimbursement	138	Direct Reimbursement Dental	
Retirees - Pending	139	DRUG	Rx Option 3
Cobra	140	SMP, RX	Med & Rx Option 1
Cobra	141	SMP, RX, SuperDental	Med & Rx Option 1
Cobra	142	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
Kaiser - Cobra	143	SuperDental	
Kaiser - Cobra	144	Direct Reimbursement Dental	
Kaiser	145	SuperDental	
Kaiser	146	Direct Reimbursement Dental	
Prisoners	200	SMP, RX	

Medical Option 1 - SMP - $10 OV copay
Medical Option 2 - SMP - $5 OV copay
Medical Option 3 - Traditional - New Hires 2004
Medical Option 4 - SMP - New Hires effective 01/01/04 (Deductible)
Medical Option 5 - SMP - $10 OV copay - Firemen only - Routine Testing
Medical Option 6 - Traditional - New Hires 2004 - Firemen only - Routine Testing
RX Option 1 - $15 Brand / $10 Single Source / $5 Generic with $10/$5 mandatory mail order
RX Option 2 - $5 Brand / $0 Generic with $10 / $5 mail order
RX Option 3 - $15 Brand / $10 Single Source / $5 Generic with $10/$5 mail order
RX Option 4 - $10 Brand / $5 Generic with $10/$5 mandatory mail order - New Hires effective 01/01/04

CITY OF PARMA - 716636			
DESCRIPTION	SECTION	BENEFIT	DESCRIPTION
Police	301	Traditional, RX, SuperDental	CLOSED 8/1/2006
Police	302	Traditional, RX, Direct Reimbursement Dental	CLOSED 8/1/2006
Fire	303	Traditional, RX, SuperDental	CLOSED 2/1/2006
Fire	304	Traditional, RX, Direct Reimbursement Dental	CLOSED 2/1/2006
Service	305	Traditional, RX, SuperDental	Med 3 - Rx Option 4
Service	306	Traditional, RX, Direct Reimbursement Dental	Med 3 - Rx Option 4
AFSCME	307	Traditional, RX, SuperDental	CLOSED 08/1/2007
AFSCME	308	Traditional, RX, Direct Reimbursement Dental	CLOSED 08/1/2007
Dispatcher	309	Traditional, RX, SuperDental	CLOSED 9/1/2006
Dispatcher	310	Traditional, RX, Direct Reimbursement Dental	CLOSED 9/1/2006
Schedule A	311	SMP, RX, SuperDental	Med & Rx Option 4
Schedule A	312	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 4
Police Supervisors	313	Traditional, RX, SuperDental	CLOSED 9/1/2006
Police Supervisors	314	Traditional, RX, Direct Reimbursement Dental	CLOSED 9/1/2006
Service Supervisors	315	SMP, RX, SuperDental	Med & Rx Option 4
Service Supervisors	316	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 4
Schedule A Court	317	Traditional, RX, SuperDental	CLOSED 08/1/2007
Schedule A Court	318	Traditional, RX, Direct Reimbursement Dental	CLOSED 08/1/2007
PT Assistant Law Directors	319	Traditional, RX, SuperDental	Med 3 - Rx Option 4
PT Assistant Law Directors	320	Traditional, RX, Direct Reimbursement Dental	Med 3 - Rx Option 4
Record Room	321	SMP, RX, SuperDental	Med & Rx Option 4
Record Room	322	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 4
Correction Officers	323	Traditional, RX, SuperDental	CLOSED 9/1/2006
Correction Officers	324	Traditional, RX, Direct Reimbursement Dental	CLOSED 9/1/2006
Public Official - New Benefits	325	SMP, RX, SuperDental	Med & Rx Option 4
Public Official - New Benefits	326	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 4
Cobra	340	SMP, RX	Med & Rx Option 4
Cobra	341	SMP, RX, SuperDental	Med & Rx Option 4
Cobra	342	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 4
Cobra	351	SMP, RX, SuperDental	
Cobra	352	SMP, Rx, Trad Dental	
Cobra	353	SMP, Rx ONLY	

Medical Option 1 - SMP - $10 OV copay
Medical Option 2 - SMP - $5 OV copay
Medical Option 3 - Traditional - New Hires 2004
Medical Option 4 - SMP - New Hires effective 01/01/04 (Deductible)
Medical Option 5 - SMP - $10 OV copay - Firemen only - Routine Testing
Medical Option 6 - Traditional - New Hires 2004 - Firemen only - Routine Testing
RX Option 1 - $15 Brand / $10 Single Source / $5 Generic with $10/$5 mandatory mail order
RX Option 2 - $5 Brand / $0 Generic with $10 / $5 mail order
RX Option 3 - $15 Brand / $10 Single Source / $5 Generic with $10/$5 mail order
RX Option 4 - $10 Brand / $5 Generic with $10/$5 mandatory mail order - New Hires effective 01/01/04

Medical Plan Designs

Medical Mutual

Effective January 1, 2006 thru January 1, 2007

Effective 2/1/06

Delete/Termed 1/1/07

City of Parma
SuperMed Plus
Firemen Only
Effective 2-1-06

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependent / 25 Student: Removal upon Birth Date	
Pre-Existing Condition Waiting Period	Not Subject to Pre-Ex	
Blood Pint Deductible	0 pints	
Lifetime Maximum	$2,500,000	
Benefit Period Deductible – Single/Family[1]	$200 / $400	$400 / $800
Coinsurance	90%	70%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	$1,000 / $2,000	$2,000 / $4,000
Physician/Office Services		
Office Visit (Illness/Injury)	90% after deductible	70% after deductible
Urgent Care Office Visit	90% after deductible	70% after deductible
Voluntary Second Surgical Opinion	90% after deductible	70% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	90% after deductible	Not Covered
Preventative Services		
Office Visit/Routine Physical Exam (One exam per benefit period)	90% after deductible	Not Covered
Well Child Care Services including Exam and Immunizations (To age nine)	90% after deductible	Not Covered
Well Child Care Laboratory Tests (To age nine)	100%	
Routine Vision Exam (employee only 1 per benefit period)	**100%**	
Routine Mammogram (One per benefit period)	100%	
Routine Hearing Exam (employee only 1 per benefit period)	**100%**	
All Routine Labs, X-rays and Medical Tests (employee only)	**100%**	
Routine Pap Test (One per benefit period)	100%	
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis	100%	
Outpatient Services		
Surgical Services	90% after deductible	70% after deductible
Diagnostic Services	100%	
Physical and Occupational Therapy – Facility and Professional (10 visits then Medical Review)	90% after deductible	70% after deductible
Chiropractic Therapy – Professional Only (Unlimited)	90% after deductible	70% after deductible

Benefits	Network	Non-Network
Speech Therapy – Facility and Professional (10 visits then Medical Review)	90% after deductible	70% after deductible
Cardiac Rehabilitation	90% after deductible	70% after deductible
Emergency use of an Emergency Room[2]	$50 copay, then 100%	
Non-Emergency use of an Emergency Room[2,3]	$50 copay, then 90%	$50 copay, then 70%
Inpatient Facility		
Semi-Private Room and Board	90% after deductible	70% after deductible
Maternity	90% after deductible	70% after deductible
Skilled Nursing Facility (100 days per benefit period)	90% after deductible	70% after deductible
Additional Services		
Allergy Testing and Treatments	90% after deductible	Not Covered
Education and Training	90% after deductible	Not Covered
Ambulance	90% after deductible	70% after deductible
Durable Medical Equipment	90% after deductible	70% after deductible
Home Healthcare	90% after deductible	Not Covered
Hospice	90% after deductible	Not Covered
Organ Transplants	90% after deductible	70% after deductible
Private Duty Nursing	90% after deductible	70% after deductible
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period)	50% after deductible	Not Covered
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	50% after deductible	50%[4] after deductible

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

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.

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

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

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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] Copay waived if admitted.
[3] The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance.
[4] Not applied to Coinsurance Out-of-Pocket Maximum.

Effective 9/1/06

Medical Plan #8 (will be eliminated as of 1/1/07)

City of Parma
SuperMed Plus
$200/$400 Deductible Plan

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birth Date	
Pre-Existing Condition Waiting Period	Not Subject to Pre-Ex	
Blood Pint Deductible	0 pints	
Lifetime Maximum	$2,500,000	
Benefit Period Deductible – Single/Family[1]	$100 / $200 September 1, 2006-December 31, 2006 then $200 / $400 January 1 – December 31 thereafter	$200 / $400 September 1, 2006– December 31, 2006 then $400 / $800 January 1 – December 31 thereafter
Coinsurance	90%	70%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	$500 / $1,000 September 1, 2006 –December 31, 2006 then $1000 / $2000 january 1 – December 31 thereafter	$1,000 / $2,000 September 1, 2006 -December 31, 2006 then $2,000 / $4000 January 1 – December 31 thereafter
Physician/Office Services		
Office Visit (Illness/Injury)	90% after deductible	70% after deductible
Urgent Care Office Visit	90% after deductible	70% after deductible
Voluntary Second Surgical Opinion	90% after deductible	70% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	90% after deductible	Not Covered
Preventative Services		
Office Visit/Routine Physical Exam (One exam per benefit period)	90% after deductible	Not Covered
Well Child Care Services including Exam and Immunizations (To age eighteen)	90% after deductible	Not Covered
Well Child Care Laboratory Tests (To age eighteen)	100%	
Routine Mammogram (One per benefit period)	100%	
Routine Pap Test (One per benefit period)	100%	
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis	100%	
Outpatient Services		
Surgical Services	90% after deductible	70% after deductible
Diagnostic Services	100%	
Physical and Occupational Therapy – Facility and Professional (10 visits then Medical Review)	90% after deductible	70% after deductible
Chiropractic Therapy – Professional Only (Unlimited)	90% after deductible	70% after deductible
Speech Therapy – Facility and Professional (10 visits then Medical Review)	90% after deductible	70% after deductible
Cardiac Rehabilitation	90% after deductible	70% after deductible
Emergency use of an Emergency Room[2]	$50 copay, then 100%	
Non-Emergency use of an Emergency Room[2,3]	$50 copay, then 90%	$50 copay, then 70%

Benefits	Network	Non-Network
Inpatient Facility		
Semi-Private Room and Board	90% after deductible	70% after deductible
Maternity	90% after deductible	70% after deductible
Skilled Nursing Facility (100 days per benefit period)	90% after deductible	70% after deductible
Additional Services		
Allergy Testing and Treatments	90% after deductible	Inpatient 70% after deductible Outpatient Not Covered
Ambulance	90% after deductible	70% after deductible
Durable Medical Equipment	90% after deductible	70% after deductible
Home Healthcare	90% after deductible	Not Covered
Hospice	90% after deductible	Not Covered
Organ Transplants	90% after deductible	70% after deductible
Private Duty Nursing	90% after deductible	70% after deductible
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period)	50%[4] after deductible	Not Covered
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	50%[4] after deductible	50%[4] after deductible

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

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 Contracting.

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.

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[1]Maximum family deductible. Member deductible is the same as single deductible.
[2]Copay waived if admitted.
[3]The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance.
[4]Not applied to Coinsurance Out-of-Pocket Maximum.

Medical Plan #9 (Schedule A Employees)

City of Parma
SuperMed Plus
$200/$400 Deductible Plan
Effective May 1, 2006

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birth Date	
Pre-Existing Condition Waiting Period	Not Subject to Pre-Ex	
Blood Pint Deductible	0 pints	
Lifetime Maximum	$2,500,000	
Benefit Period Deductible – Single/Family[1]	$200 / $400	$400 / $800
Coinsurance	90%	70%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	$1,000 / $2,000	$2,000 / $4,000
Physician/Office Services		
Office Visit (Illness/Injury)	90% after deductible	70% after deductible
Urgent Care Office Visit	90% after deductible	70% after deductible
Voluntary Second Surgical Opinion	90% after deductible	70% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	90% after deductible	Not Covered
Preventative Services		
Office Visit/Routine Physical Exam (One exam per benefit period)	90% after deductible	Not Covered
Well Child Care Services including Exam and Immunizations (To age eighteen)	90% after deductible	Not Covered
Well Child Care Laboratory Tests (To age eighteen)	100%	
Routine Mammogram (One per benefit period)	100%	
Routine Pap Test (One per benefit period)	100%	
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis	100%	
Outpatient Services		
Surgical Services	90% after deductible	70% after deductible
Diagnostic Services	100%	
Physical and Occupational Therapy – Facility and Professional (10 visits then Medical Review)	90% after deductible	70% after deductible
Chiropractic Therapy – Professional Only (Unlimited)	90% after deductible	70% after deductible
Speech Therapy – Facility and Professional (10 visits then Medical Review)	90% after deductible	70% after deductible
Cardiac Rehabilitation	90% after deductible	70% after deductible
Emergency use of an Emergency Room[2]	$50 copay, then 100%	
Non-Emergency use of an Emergency Room[2,3]	$50 copay, then 90%	$50 copay, then 70%

Benefits	Network	Non-Network
Inpatient Facility		
Semi-Private Room and Board	90% after deductible	70% after deductible
Maternity	90% after deductible	70% after deductible
Skilled Nursing Facility (100 days per benefit period)	90% after deductible	70% after deductible
Additional Services		
Allergy Testing and Treatments	90% after deductible	Inpatient 70% after deductible Outpatient Not Covered
Ambulance	90% after deductible	70% after deductible
Durable Medical Equipment	90% after deductible	70% after deductible
Home Healthcare	90% after deductible	Not Covered
Hospice	90% after deductible	Not Covered
Organ Transplants	90% after deductible	70% after deductible
Private Duty Nursing	90% after deductible	70% after deductible
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period)	50%[4] after deductible	Not Covered
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	50%[4] after deductible	50%[4] after deductible

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

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 Contracting.

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.

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[1]Maximum family deductible. Member deductible is the same as single deductible.
[2]Copay waived if admitted.
[3]The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance.
[4]Not applied to Coinsurance Out-of-Pocket Maximum.

Kaiser Permanente HMO

Rate Listing
for CITY OF PARMA - 0102 CITY OF PARMA
Renewal-Current Plan Design
Rates Effective 1/1/2006 - 12/31/2006

OUTPATIENT CARE	
Office Visits including:	
•Exams, allergy testing, well-child care, hearing tests	$10 per visit
•Allergy treatment	No Charge
•Outpatient surgery	$10 per visit
•Specialty care	$10 per visit
•Vision Exams available through affiliated providers	$10 per visit
Prenatal Care	No Charge
Urgent Care	
•At Kaiser Permanente facilities or outside the service area	$10 per visit
Physical, Speech, and Occupational Therapy	$10 per visit
•Up to 2 months or 30 visits per therapy, whichever is greater, per medical episode	
DIAGNOSTIC SERVICES	
•Laboratory and diagnostic testing, X-rays	No Charge
HOSPITAL INPATIENT CARE	
No annual or lifetime limit on covered days, including:	No Charge
•Physician and surgeon services; Room and board, anesthesia, operating and recovery rooms; Laboratory and diagnostic testing, x-rays	
EMERGENCY SERVICES (Fee waived if admitted)	
Emergency Services provided at a Plan Facility	$10 per visit
Emergency Services provided at a non-Plan Facility	$10 per visit
AMBULANCE SERVICES	
Only when transportation in any other vehicle would endanger your health	No Charge
MENTAL HEALTH SERVICES	
Inpatient - 30 days of hospital care per calendar year	No Charge
Outpatient - 20 visit maximum	
•Individual Therapy	$10 per visit
•Group Therapy(each visit counts as one-half visit against maximum)	$5 per visit
CHEMICAL DEPENDENCY SERVICES	
Inpatient	
•Detoxification in a general hospital	No Charge
•Detoxification in a specialized facility–1 admit per year	No Charge
Outpatient	
•Detoxification	$10 per visit
•Individual Therapy	$10 per visit
•Group Therapy	$5 per day
ALTERNATE CARE	
Home Health Services	No Charge
Hospice Home Care/Respite Care	No Charge
Skilled care in a Skilled Nursing Facility	No Charge
•Up to 100 days per calendar year	
INFERTILITY SERVICES	
•Inpatient	30%*
•Outpatient	30%
PRESCRIPTION DRUGS	

•Covered Formulary Drugs and Accessories up to a 31 day supply at Kaiser Permanente and affiliated network facilities •Up to 62 day supply of maintenance drugs by mail order from the Kaiser Permanente Mail Order Pharmacy	$5 copay
DURABLE MEDICAL EQUIPMENT Coverage limited to specific durable medical equipment	No Charge

*When a plan deductible is indicated, inpatient infertility services are subject to deductible.

Notes and Restrictions

- Rates are monthly and based upon census submitted. Final rates will be based on actual enrollment.
- Do not cancel your current medical coverage until you have received approval from Kaiser Permanente.
- Medicare eligible employees working for groups with less than 20 employees are NOT ELIGIBLE for Added Choice coverage.
- Final risk category determined by medical evaluation.
- The benefits listed above are only a summary. Detailed benefit information and exclusions are available on request.

C.

2005 Structure -

CITY OF PARMA - 716636			
DESCRIPTION	SECTION	BENEFIT	DESCRIPTION
Police	101	SMP, RX, SuperDental	Med & Rx Option 1
Police	102	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
Fire	103	SMP, RX, SuperDental	Med Option 5 & Rx Option 1
Fire	104	SMP, RX, Direct Reimbursement Dental	Med Option 5 & Rx Option 1
Service	105	SMP, RX, SuperDental	Med & Rx Option 1
Service	106	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
AFSCME	107	SMP, RX, SuperDental	Med & Rx Option 1
AFSCME	108	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
Dispatcher	109	SMP, RX, SuperDental	Med & Rx Option 1
Dispatcher	110	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
Schedule A	111	SMP, RX, SuperDental	Med & Rx Option 1
Schedule A	112	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
Police Supervisors	113	SMP, RX, SuperDental	Med & Rx Option 1
Police Supervisors	114	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
Service Supervisors	115	SMP, RX, SuperDental	Med & Rx Option 1
Service Supervisors	116	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
Schedule A Court	117	SMP, RX, SuperDental	Med & Rx Option 1
Schedule A Court	118	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
PT Assistant Law Directors	119	SMP, RX, SuperDental	Med & Rx Option 1
PT Assistant Law Directors	120	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
Record Room	121	SMP, RX, SuperDental	Med & Rx Option 1
Record Room	122	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
Correction Officers	123	SMP, RX, SuperDental	Med & Rx Option 1
Correction Officers	124	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
Public Official - New Benefits	125	SMP, RX, SuperDental	Med & Rx Option 1
Public Official - New Benefits	126	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
Public Official - Old Benefits	127	SMP, RX, SuperDental	Med & Rx Option 2
Public Official - Old Benefits	128	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 2
Employee Senior Dependents	129	SMP, RX, SuperDental	Med & Rx Option 1
Employee Senior Dependents	130	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
Close	131		
Retirees with FT Students	132	SMP, RX	Med & Rx Option 1
Old Retirees	133	Cost Logic (SuperDental)	Manual
Old Retirees	134	MMO (Direct Reimbursement Dental)	Manual
Close	135		
Close	136		
Retirees SuperDental	137	SuperDental	
Retirees Direct Reimbursement	138	Direct Reimbursement Dental	
Retirees - Pending	139	DRUG	Rx Option 3
Cobra	140	SMP, RX	Med & Rx Option 1
Cobra	141	SMP, RX, SuperDental	Med & Rx Option 1
Cobra	142	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 1
Kaiser - Cobra	143	SuperDental	
Kaiser - Cobra	144	Direct Reimbursement Dental	
Kaiser	145	SuperDental	
Kaiser	146	Direct Reimbursement Dental	
Prisoners	200	SMP, RX	

Medical Option 1 - SMP - $10 OV copay
Medical Option 2 - SMP - $5 OV copay
Medical Option 3 - Traditional - New Hires 2004
Medical Option 4 - SMP - New Hires effective 01/01/04 (Deductible)
Medical Option 5 - SMP - $10 OV copay - Firemen only - Routine Testing
Medical Option 6 - Traditional - New Hires 2004 - Firemen only - Routine Testing
RX Option 1 - $15 Brand / $10 Single Source / $5 Generic with $10/$5 mandatory mail order
RX Option 2 - $5 Brand / $0 Generic with $10 / $5 mail order
RX Option 3 - $15 Brand / $10 Single Source / $5 Generic with $10/$5 mail order
RX Option 4 - $10 Brand / $5 Generic with $10/$5 mandatory mail order - New Hires effective 01/01/04

CITY OF PARMA - 716636			
DESCRIPTION	SECTION	BENEFIT	DESCRIPTION
Police	301	Traditional, RX, SuperDental	Med 3 - Rx Option 4
Police	302	Traditional, RX, Direct Reimbursement Dental	Med 3 - Rx Option 4
Fire	303	Traditional, RX, SuperDental	Med 6 - Rx Option 4
Fire	304	Traditional, RX, Direct Reimbursement Dental	Med 6 - Rx Option 4
Service	305	Traditional, RX, SuperDental	Med 3 - Rx Option 4
Service	306	Traditional, RX, Direct Reimbursement Dental	Med 3 - Rx Option 4
AFSCME	307	Traditional, RX, SuperDental	Med 3 - Rx Option 4
AFSCME	308	Traditional, RX, Direct Reimbursement Dental	Med 3 - Rx Option 4
Dispatcher	309	Traditional, RX, SuperDental	Med 3 - Rx Option 4
Dispatcher	310	Traditional, RX, Direct Reimbursement Dental	Med 3 - Rx Option 4
Schedule A	311	SMP, RX, SuperDental	Med & Rx Option 4
Schedule A	312	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 4
Police Supervisors	313	Traditional, RX, SuperDental	Med 3 - Rx Option 4
Police Supervisors	314	Traditional, RX, Direct Reimbursement Dental	Med 3 - Rx Option 4
Service Supervisors	315	SMP, RX, SuperDental	Med & Rx Option 4
Service Supervisors	316	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 4
Schedule A Court	317	Traditional, RX, SuperDental	Med 3 - Rx Option 4
Schedule A Court	318	Traditional, RX, Direct Reimbursement Dental	Med 3 - Rx Option 4
PT Assistant Law Directors	319	Traditional, RX, SuperDental	Med 3 - Rx Option 4
PT Assistant Law Directors	320	Traditional, RX, Direct Reimbursement Dental	Med 3 - Rx Option 4
Record Room	321	SMP, RX, SuperDental	Med & Rx Option 4
Record Room	322	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 4
Correction Officers	323	Traditional, RX, SuperDental	Med 3 - Rx Option 4
Correction Officers	324	Traditional, RX, Direct Reimbursement Dental	Med 3 - Rx Option 4
Public Official - New Benefits	325	SMP, RX, SuperDental	Med & Rx Option 4
Public Official - New Benefits	326	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 4
Cobra	340	SMP, RX	Med & Rx Option 4
Cobra	341	SMP, RX, SuperDental	Med & Rx Option 4
Cobra	342	SMP, RX, Direct Reimbursement Dental	Med & Rx Option 4

Medical Option 1 - SMP - $10 OV copay
Medical Option 2 - SMP - $5 OV copay
Medical Option 3 - Traditional - New Hires 2004
Medical Option 4 - SMP - New Hires effective 01/01/04 (Deductible)
Medical Option 5 - SMP - $10 OV copay - Firemen only - Routine Testing
Medical Option 6 - Traditional - New Hires 2004 - Firemen only - Routine Testing
RX Option 1 - $15 Brand / $10 Single Source / $5 Generic with $10/$5 mandatory mail order
RX Option 2 - $5 Brand / $0 Generic with $10 / $5 mail order
RX Option 3 - $15 Brand / $10 Single Source / $5 Generic with $10/$5 mail order
RX Option 4 - $10 Brand / $5 Generic with $10/$5 mandatory mail order - New Hires effective 01/01/04

Medical Plan Designs

Medical Mutual

Effective January 1, 2003 thru January 1, 2007

Effective 1/1/03

City of Parma
SuperMed Plus
Option 1

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birth Date	
Lifetime Maximum	$2,500,000	
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)[2]	$10 copay, then 100%	80% after deductible
Urgent Care Facility Services[2]	$10 copay, then 100%	80% after deductible
Voluntary Second Surgical Opinion	100%	80% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	100%	Not Covered
Preventative Services		
Office Visit/Routine Physical Exams[2]	$10 copay, then 100%	Not Covered
Well Child Care Exams (To age eighteen)[2]	$10 copay, then 100%	Not Covered
Well Child Care Immunizations (To age eighteen)	100%	Not Covered
Well Child Care Laboratory Tests (To age eighteen)	100%	
Routine Mammogram (One, limited to an $85 maximum per benefit period)	100%	
Routine Pap Test	100%	
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis	100%	
Outpatient Services		
Surgical Services	100%	80% after deductible
Diagnostic Services	100%	
Physical and Occupational Therapy – Facility and Professional (10 visits then Medical Review)	100%	80% after deductible
Chiropractic Therapy – Professional Only (Unlimited)	$10 copay, then 100%	80% after deductible
Speech Therapy – Facility and Professional (10 visits then Medical Review)	100%	80% after deductible
Cardiac Rehabilitation	100%	80% after deductible
Emergency use of an Emergency Room	100%	
Non-Emergency use of an Emergency Room[3,4]	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%	Not Covered
Ambulance	100%	80% after deductible
Durable Medical Equipment	100%	80% after deductible
Education and Training	100%	Not Covered
Family Planning	100%	Not Covered
Home Healthcare	100%	Not Covered
Hospice	100%	Not Covered
Organ Transplants	100%	80% after deductible
Private Duty Nursing	100%	80% after deductible
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period, three admissions per lifetime)	100%	Not Covered
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	$10 copay, then 100%	50%[5] after deductible

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

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

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]Copay waived if admitted
[4]The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance.
[5]Not applied to Coinsurance Out-of-Pocket Maximum.

Efective 1/1/03

City of Parma
SuperMed Plus
Option 2

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birth Date	
Lifetime Maximum	$2,500,000	
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)[2]	$5 copay, then 100%	80% after deductible
Urgent Care Facility Services[2]	$5 copay, then 100%	80% after deductible
Voluntary Second Surgical Opinion	100%	80% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	100%	Not Covered
Preventative Services		
Office Visit/Routine Physical Exams[2]	$5 copay, then 100%	Not Covered
Well Child Care Exams (To age eighteen)[2]	$5 copay, then 100%	Not Covered
Well Child Care Immunizations (To age eighteen)	100%	Not Covered
Well Child Care Laboratory Tests (To age eighteen)	100%	
Routine Mammogram (One, limited to an $85 maximum per benefit period)	100%	
Routine Pap Test	100%	
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis	100%	
Outpatient Services		
Surgical Services	100%	80% after deductible
Diagnostic Services	100%	
Physical and Occupational Therapy – Facility and Professional (10 visits then Medical Review)	100%	80% after deductible
Chiropractic Therapy – Professional Only (Unlimited)	$5 copay, then 100%	80% after deductible
Speech Therapy – Facility and Professional (10 visits then Medical Review)	100%	80% after deductible
Cardiac Rehabilitation	100%	80% after deductible
Emergency use of an Emergency Room	100%	
Non-Emergency use of an Emergency Room[3,4]	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%	Not Covered
Ambulance	100%	80% after deductible
Durable Medical Equipment	100%	80% after deductible
Education and Training	100%	Not Covered
Family Planning	100%	Not Covered
Home Healthcare	100%	Not Covered
Hospice	100%	Not Covered
Organ Transplants	100%	80% after deductible
Private Duty Nursing	100%	80% after deductible
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period, three admissions per lifetime)	100%	Not Covered
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	$5 copay, then 100%	50%[5] after deductible

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

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

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

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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]Copay waived if admitted
[4]The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance.
[5]Not applied to Coinsurance Out-of-Pocket Maximum

Effective 1/1/04

City of Parma
Traditional
New Hires Effective 01/01/04
Medical Plan 3

Benefits	
Benefit Period	January 1st through December 31st
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birth Date
Pre-Existing Condition Waiting Period	Not Subject to Pre-Ex
Blood Pint Deductible	0 pints
Lifetime Maximum	$2,500,000
Benefit Period Deductible – Single/Family[1]	$200 / $400
Coinsurance	80%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	$1,000 / $2,000
Physician/Office Services	
Office Visit (Illness/Injury)	80% after deductible
Urgent Care Office Visit	80% after deductible
Voluntary Second Surgical Opinion	80% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	80% after deductible
Preventative Services	
Office Visit/Routine Physical Exam (One exam per benefit period)	80% after deductible
Well Child Care Services including Exam and Immunizations (To age nine)	80% after deductible
Well Child Care Laboratory Tests (To age nine)	100%
Routine Mammogram (One, limited to an $85 maximum per benefit period)	100%
Routine Pap Test (One per benefit period)	100%
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis	100%
Outpatient Services	
Surgical Services	80% after deductible
Diagnostic Services	100%
Physical and Occupational Therapy - Facility and Professional (10 visits then Medical Review)	80% after deductible
Chiropractic Therapy – Professional Only (Unlimited)	80% after deductible
Speech Therapy – Facility and Professional (10 visits then Medical Review)	80% after deductible
Cardiac Rehabilitation	80% after deductible
Emergency use of an Emergency Room[2]	$50 copay, then 100%
Non-Emergency use of an Emergency Room[2,3]	$50 copay, then 80%

Benefits	
Inpatient Facility	
Semi-Private Room and Board	80% after deductible
Maternity	80% after deductible
Skilled Nursing Facility (100 days per benefit period)	80% after deductible
Additional Services	
Allergy Testing and Treatments	80% after deductible
Ambulance	80% after deductible
Durable Medical Equipment	80% after deductible
Home Healthcare	80% after deductible
Hospice	80% after deductible
Organ Transplants	80% after deductible
Private Duty Nursing	80% after deductible
Mental Health and Substance Abuse	
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period)	50% after deductible
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	50% after deductible

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

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

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
[3]The copay applies to room charges only All other covered charges are subject to deductible and coinsurance

Effective 1/1/04

City of Parma
SuperMed Plus
New Hires Effective 01/01/04
Medical Plan 4

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birth Date	
Pre-Existing Condition Waiting Period	Not Subject to Pre-Ex	
Blood Pint Deductible	0 pints	
Lifetime Maximum	$2,500,000	
Benefit Period Deductible – Single/Family[1]	$200 / $400	
Coinsurance	80%	70%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	$1,000 / $2,000	$1,500 / $3,000
Physician/Office Services		
Office Visit (Illness/Injury)	80% after deductible	70% after deductible
Urgent Care Office Visit	80% after deductible	70% after deductible
Voluntary Second Surgical Opinion	80% after deductible	70% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	80% after deductible	Not Covered
Preventative Services		
Office Visit/Routine Physical Exam (One exam per benefit period)	80% after deductible	Not Covered
Well Child Care Services including Exam and Immunizations (To age nine)	80% after deductible	Not Covered
Well Child Care Laboratory Tests (To age nine)	100%	
Routine Mammogram (One, limited to an $85 maximum per benefit period)	100%	
Routine Pap Test (One per benefit period)	100%	
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis	100%	
Outpatient Services		
Surgical Services	80% after deductible	70% after deductible
Diagnostic Services	100%	
Physical and Occupational Therapy – Facility and Professional (10 visits then Medical Review)	80% after deductible	70% after deductible
Chiropractic Therapy – Professional Only (Unlimited)	80% after deductible	70% after deductible
Speech Therapy – Facility and Professional (10 visits then Medical Review)	80% after deductible	70% after deductible
Cardiac Rehabilitation	80% after deductible	70% after deductible
Emergency use of an Emergency Room[2]	$50 copay, then 100%	
Non-Emergency use of an Emergency Room[2 3]	$50 copay, then 80%	$50 copay, then 70%

Benefits	Network	Non-Network
Inpatient Facility		
Semi-Private Room and Board	80% after deductible	70% after deductible
Maternity	80% after deductible	70% after deductible
Skilled Nursing Facility (100 days per benefit period)	80% after deductible	70% after deductible
Additional Services		
Allergy Testing and Treatments	80% after deductible	Not Covered
Ambulance	80% after deductible	70% after deductible
Durable Medical Equipment	80% after deductible	70% after deductible
Home Healthcare	80% after deductible	Not Covered
Hospice	80% after deductible	Not Covered
Organ Transplants	80% after deductible	70% after deductible
Private Duty Nursing	80% after deductible	70% after deductible
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period)	50% after deductible	Not Covered
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	50% after deductible	50%[4] after deductible

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

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 Contracting.

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]Copay waived if admitted
[3]The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance
[4]Not applied to Coinsurance Out-of-Pocket Maximum

Delete/Termed 1/1/07

City of Parma
SuperMed Plus
Option 5
Firemen Only

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birth Date	
Lifetime Maximum	$2,500,000	
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)[2]	$10 copay, then 100%	80% after deductible
Urgent Care Facility Services[2]	$10 copay, then 100%	80% after deductible
Voluntary Second Surgical Opinion	100%	80% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	100%	Not Covered
Preventative Services		
Office Visit/Routine Physical Exams[2]	$10 copay, then 100%	Not Covered
Well Child Care Exams (To age eighteen)[2]	$10 copay, then 100%	Not Covered
Well Child Care Immunizations (To age eighteen)	100%	Not Covered
Well Child Care Laboratory Tests (To age eighteen)	100%	
Routine Hearing Exam (Employee only)	100%	
Routine Vision Exam (Employee only)	100%	
Routine Mammogram (One, limited to an $85 maximum per benefit period)	100%	
Routine Pap Test	100%	
All Routine Labs, X-rays and Medical Tests (Employee only)	100%	
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis	100%	
Outpatient Services		
Surgical Services	100%	80% after deductible
Diagnostic Services	100%	
Physical and Occupational Therapy – Facility and Professional (10 visits then Medical Review)	100%	80% after deductible
Chiropractic Therapy – Professional Only (Unlimited)	$10 copay, then 100%	80% after deductible
Speech Therapy – Facility and Professional (10 visits then Medical Review)	100%	80% after deductible
Cardiac Rehabilitation	100%	80% after deductible
Emergency use of an Emergency Room	100%	
Non-Emergency use of an Emergency Room[3,4]	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%	Not Covered
Ambulance	100%	80% after deductible
Durable Medical Equipment	100%	80% after deductible
Education and Training	100%	Not Covered
Family Planning	100%	Not Covered
Home Healthcare	100%	Not Covered
Hospice	100%	Not Covered
Organ Transplants	100%	80% after deductible
Private Duty Nursing	100%	80% after deductible
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period, three admissions per lifetime)	100%	Not Covered
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	$10 copay, then 100%	50%[5] after deductible

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

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

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]Copay waived if admitted
[4]The copay applies to room charges only All other covered charges are subject to deductible and coinsurance
[5]Not applied to Coinsurance Out-of-Pocket Maximum

City of Parma
Traditional
New Hires Effective 01/01/04
Firemen Only
Medical Plan 6

Benefits	
Benefit Period	January 1st through December 31st
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birth Date
Pre-Existing Condition Waiting Period	Not Subject to Pre-Ex
Blood Pint Deductible	0 pints
Lifetime Maximum	$2,500,000
Benefit Period Deductible – Single/Family[1]	$200 / $400
Coinsurance	80%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	$1,000 / $2,000
Physician/Office Services	
Office Visit (Illness/Injury)	80% after deductible
Urgent Care Office Visit	80% after deductible
Voluntary Second Surgical Opinion	80% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	80% after deductible
Preventative Services	
Office Visit/Routine Physical Exam (One exam per benefit period)	80% after deductible
Well Child Care Services including Exam and Immunizations (To age nine)	80% after deductible
Well Child Care Laboratory Tests (To age nine)	100%
Routine Hearing Exam (Employee only)	100%
Routine Vision Exam (Employee only)	100%
Routine Mammogram (One, limited to an $85 maximum per benefit period)	100%
Routine Pap Test (One per benefit period)	100%
All Routine Labs, X-rays and Medical Tests (Employee only)	100%
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis	100%
Outpatient Services	
Surgical Services	80% after deductible
Diagnostic Services	100%
Physical and Occupational Therapy - Facility and Professional (10 visits then Medical Review)	80% after deductible
Chiropractic Therapy – Professional Only (Unlimited)	80% after deductible
Speech Therapy – Facility and Professional (10 visits then Medical Review)	80% after deductible
Cardiac Rehabilitation	80% after deductible
Emergency use of an Emergency Room[2]	$50 copay, then 100%
Non-Emergency use of an Emergency Room[2,3]	$50 copay, then 80%

Benefits	
Inpatient Facility	
Semi-Private Room and Board	80% after deductible
Maternity	80% after deductible
Skilled Nursing Facility (100 days per benefit period)	80% after deductible
Additional Services	
Allergy Testing and Treatments	80% after deductible
Ambulance	80% after deductible
Durable Medical Equipment	80% after deductible
Home Healthcare	80% after deductible
Hospice	80% after deductible
Organ Transplants	80% after deductible
Private Duty Nursing	80% after deductible
Mental Health and Substance Abuse	
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period)	50% after deductible
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	50% after deductible

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

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

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

Effective 1/1/05

KAISER PERMANENTE®

Kaiser Permanente HMO BENEFITS AND SERVICES

Medical services provided or arranged by your Kaiser Permanente physician

For CITY OF PARMA

	MEMBER PAYS
OUTPATIENT CARE	
Office Visits including:	
• Exams, allergy testing, well-child care, hearing tests	$10 per visit
• Allergy treatment	No Charge
• Outpatient surgery	$10 per visit
• Specialty care	$10 per visit
• Vision Exams available through affiliated providers	$10 per visit
Prenatal Care	No Charge
Urgent Care	
• At Kaiser Permanente facilities or outside the service area	$10 per visit
Physical, Speech, and Occupational Therapy	$10 per visit
• Up to 2 months or 30 visits per therapy, whichever is greater, per medical episode	
DIAGNOSTIC SERVICES	
• Laboratory and diagnostic testing, X-rays	No Charge
HOSPITAL INPATIENT CARE	
No annual or lifetime limit on covered days, including:	No Charge
• Physician and surgeon services; Room and board, anesthesia, operating and recovery rooms; Laboratory and diagnostic testing, x-rays	
EMERGENCY SERVICES (Fee waived if admitted)	
Emergency Services provided at a Plan Facility	$10 per visit
Emergency Services provided at a non-Plan Facility	$10 per visit
AMBULANCE SERVICES	
Only when transportation in any other vehicle would endanger your health	No Charge
MENTAL HEALTH SERVICES	
Inpatient - 30 days of hospital care per calendar year	No Charge
Outpatient - 20 visit maximum	
• Individual Therapy	$10 per visit
• Group Therapy(each visit counts as one-half visit against maximum)	$5 per visit
CHEMICAL DEPENDENCY SERVICES	
Inpatient	
• Detoxification in a general hospital	No Charge
• Detoxification in a specialized facility--1 admit per year	No Charge
Outpatient	
• Detoxification	$10 per visit
• Individual Therapy	$10 per visit
• Group Therapy	$5 per day
ALTERNATE CARE	
Home Health Services	No Charge
Hospice Home Care/Respite Care	No Charge
Skilled care in a Skilled Nursing Facility	No Charge
• Up to 100 days per calendar year	
INFERTILITY SERVICES	
• Inpatient	30%*
• Outpatient	30%

PRESCRIPTION DRUGS

KAISER PERMANENTE®

Kaiser Permanente HMO BENEFITS AND SERVICES

Medical services provided or arranged by your Kaiser Permanente physician	MEMBER PAYS
• Covered Formulary Drugs and Accessories up to a 31 day supply at Kaiser Permanente and affiliated network facilities • Up to 62 day supply of maintenance drugs by mail order from the Kaiser Permanente Mail Order Pharmacy	$5 copay
DURABLE MEDICAL EQUIPMENT	
Coverage limited to specific durable medical equipment	No Charge
EXTENDED DEPENDENT COVERAGE	
• Dependents are covered up to age 19 at the end of the month • Full-Time Students are covered up to age 25 at the end of the month	

*When a plan deductible is indicated, inpatient infertility services are subject to deductible

This summary of benefits contains highlights only.
This is not a contract. Specific benefits, exclusions and limitations are contained in the Group Agreement we have with your employer and the Evidence of Coverage you will receive when you become a member. For specific questions about coverage, existing Members may call our Customer Relations Department at (216) 621-7100 or toll-free at 1-800-686-7100. New Members may call a Kaiser Permanente Representative at (216) 479-5770 or toll-free at 1-800-400-1907. Our TTY line is (216) 635-4444 for the hearing impaired

Out of Pocket Maximum
The Plan's Deductible, any benefit specific deductible, and the following benefits do not apply towards the satisfaction of the Out of Pocket Maximum: Copayments and Coinsurance on services that are not Basic Health Care Services, such as but not limited to: Skilled Nursing, Durable Medical Equipment/Prosthetics and Orthotics, and Prescription Drug Benefits

General Exclusions including but not limited to:
• Services that are not medically necessary • Services and supplies not provided, arranged or authorized by a Plan Physician • Alternative medical services including acupuncture • Alternative reproductive technologies such as: In vitro fertilization, ovum transplants, gamete intrafallopian transfer, zygote intrafallopian transfer, donor semen, donor eggs and services related to their procurement and storage • Non-Mental Health biofeedback services • Cosmetic surgery or services • Custodial or intermediate care • Hypnotherapy and Hypnotic anesthesia • Certain Physical examinations • Services related to sexual reassignment • Experimental or investigational services • Services that are the financial responsibility of an employer or services or a government agency • Services provided under any Workers' Compensation or employer's liability law • Cardiac rehabilitation • Non-human or artificial organs and their implantation • Reversal of voluntary infertility • Long term rehabilitation.

Health Plan Drug Formulary

Kaiser Foundation Health Plan of Ohio uses a closed drug formulary The medications included in the Kaiser Permanente Formulary are chosen by a group of Kaiser Permanente physicians, pharmacists, and nurses known as the Pharmacy and Therapeutics Committee. This Committee meets regularly to evaluate and choose those medications that are effective, safe, and useful in caring for our members Non-formulary drugs may be approved for coverage if certain criteria are met

Please note that some Kaiser Permanente health benefit plans provide coverage of non-formulary drugs at a higher non-formulary copayment

Not all Kaiser Permanente health benefit plans include coverage for prescription drugs Some drugs may be excluded from coverage Some plans have limitations on the dollar amount of coverage Some medications may have quantity restrictions limiting the amount of the drug you can receive per prescription or copayment. Coverage of certain formulary medications may also be subject to restrictions established by the Pharmacy and Therapeutics Committee.

For more information regarding our prescription drug benefit procedures or your benefit, please call our Customer Relations Department at 216-621-7100 or 1-800-686-7100 or visit *kaiserpermanente.org* to view the Member Drug Formulary

Additional Kaiser Permanente Services

As a Kaiser Permanente member, you will have access to complimentary services and discount programs All subscribers receive a copy of our Healthwise Handbook and subscription to our *Partners in Health* magazine The Healthwise Handbook is a self-care manual that includes basic guidelines on recognizing and coping with some of the most common health problems *Partners in Health* is a magazine containing articles addressing current health issues, health and wellness topics, as well as self-care topics. To supplement these two publications, all members have access to our website, *kaiserpermanente.org*, and our telephone advice line. Through *kaiserpermanente.org* members can access information on featured health topics, search for specific topics in our health and drug encyclopedias, participate in discussion boards, schedule non-urgent appointments, refill prescriptions, order ID cards, and email questions to an advice nurse, pharmacist, and/or member service representative Members also have access to our Telephone Advice line 24 hours a day, 7 days a week. Kaiser Permanente registered nurses with training in various medical specialties staff the phone lines

Kaiser Permanente believes that health care does not necessarily begin and end in the doctor's office. We believe that the integration of self-care skills into our everyday interactions with our members can produce some powerful and positive outcomes resulting in healthier and more satisfied members

d.

Prescription Drug Plan Designs

Medical Mutual

Effective January 1, 2006 thru January 1, 2008

City of Parma
Prescription Drug Program
Effective April 1, 2006

Benefits	Copay	Day Supply
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birth Date	
Formulary Retail Program with Oral Contraceptive Coverage – mandatory mail order after the second retail fill of a prescription drug		
Generic Copayment	$10	30
Formulary Copayment	$20	30
Non-Formulary Copayment	$30	30
Formulary Mail Order Program with Oral Contraceptive Coverage		
Generic Copayment	$25	90
Formulary Copayment	$50	90
Non-Formulary Copayment	$75	90

Note: In an effort to continue our commitment to quality care and help contain the increasing cost of prescription drug coverage, a formulary feature is included in your prescription drug benefit. A formulary drug is a FDA approved prescription medication reviewed by an independent Pharmacy and Therapeutics Committee brought together by Medco Health Solutions, Inc. Formulary drugs can assist in maintaining quality care while meeting your plan's cost containment objectives.

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.

e.

Prescription Drug Plan Designs

Medical Mutual

Effective January 1, 2003 thru January 1, 2008

Effective 1/1/03

City of Parma
Prescription Drug Program 1
Mandatory Mail Order

Benefits	Copay	Day Supply
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birth Date	
Retail Program with Oral Contraceptive Coverage – for the initial filling and one refill of a prescription drug		
Generic Copayment	$5	30
Single Source Copayment	$10	30
Brand Copayment	$15	30
Retail Program with Oral Contraceptive Coverage – after the second retail fill of a prescription drug		
Generic Copayment	Not Covered	N/A
Single Source Copayment	Not Covered	N/A
Brand Copayment	Not Covered	N/A
Mail Order Program with Oral Contraceptive Coverage		
Generic Copayment	$5	90
Brand Copayment	$10	90

Note: In an effort to continue our commitment to quality care and help contain the increasing cost of prescription drug coverage, a preferred feature is included in your prescription drug benefit A preferred drug is a FDA approved prescription medication reviewed by an independent Pharmacy and Therapeutics Committee brought together by Merck-Medco Managed Care, L L C Preferred drugs can assist in maintaining quality care while meeting your plan's cost containment objectives.

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

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Effective 1/1/03

City of Parma
Prescription Drug Program 2

Benefits	Copay	Day Supply
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birth Date	
Retail Program with Oral Contraceptive Coverage		
Generic Copayment	$0	34
Brand Name Copayment	$5	34
Mail Order Program with Oral Contraceptive Coverage		
Generic Copayment	$5	90
Brand Name Copayment	$10	90

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

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Prescription Drug Program 3

City of Parma
Prescription Drug Program
Section 139 only

Benefits	Copay	Day Supply
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birth Date	
Retail Program with Oral Contraceptive Coverage		
Generic Copayment	$5	30
Single Source Copayment	$10	30
Brand Name Copayment	$15	30
Mail Order Program with Oral Contraceptive Coverage		
Generic Copayment	$5	90
Brand Name Copayment	$10	90

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

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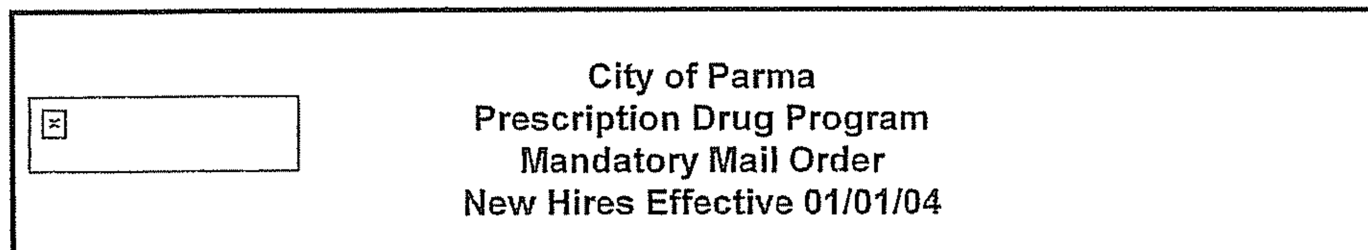
Effective 1/1/04

Prescription Drug Program 4



City of Parma
Prescription Drug Program
Mandatory Mail Order
New Hires Effective 01/01/04

Benefits	Copay	Day Supply
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birth Date	
Retail Program with Oral Contraceptive Coverage – for the initial filling and one refill of a prescription drug		
Generic Copayment	$5	34
Brand Copayment	$10	34
Retail Program with Oral Contraceptive Coverage – after the second retail fill of a prescription drug		
Generic Copayment	Not Covered	N/A
Brand Copayment	Not Covered	N/A
Mail Order Program with Oral Contraceptive Coverage		
Generic Copayment	$5	90
Brand Copayment	$10	90

Note: In an effort to continue our commitment to quality care and help contain the increasing cost of prescription drug coverage, a preferred feature is included in your prescription drug benefit. A preferred drug is a FDA approved prescription medication reviewed by an independent Pharmacy and Therapeutics Committee brought together by Merck-Medco Managed Care, L L C Preferred drugs can assist in maintaining quality care while meeting your plan's cost containment objectives.

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

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f.

Dental Plan Designs

Medical Mutual

Effective January 1, 2003 thru January 1, 2008

Effective 1/1/03

City of Parma Traditional Dental With Orthodontia

Benefits	
Benefit Period	January 1st through December 31st
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birth Date
Benefit Period Maximum (per member)	$1,500
Benefit Period Deductible (per member)	$50
Orthodontic Lifetime Maximum (per eligible dependent up to age 19)	$1,500
Periodontal Lifetime Maximum (per member)	$3,000
Preventive, Restorative and Complex Services	
First $150 of services	100% of billed charges
$151 - $200 of services (next $50)	Apply $50 deductible
$201 - $700 of services (next $500)	80% of billed charges
$701 - $2,427.28 of services (next $1727.28)	55% of billed charges
Periodontal Services	
Periodontal Services	60% UCR after deductible
Orthodontic Services	
Orthodontic Diagnostic Services	60% UCR after deductible
Minor Treatment for Tooth Guidance	60% UCR after deductible
Minor Treatment for Harmful Habits	60% UCR after deductible
Interceptive Orthodontic Treatment	60% UCR after deductible
Comprehensive Orthodontic Treatment	60% UCR after deductible

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

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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

Effective 10/1/02

City of Parma
SuperDental

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependent / 25 Student; Removal upon End of Month	
Benefit Period Maximum (per member)	$1,500	
Benefit Period Deductible (per member)	$50	
Orthodontic Lifetime Maximum (per eligible dependent up to age 19)	$1,500	
Periodontal Lifetime Maximum (per member)	$3,000	
Preventive Services[1]		
Oral Exams – two per benefit period	$10 copay, then 100%	Not Covered
Bite Wing X-Rays – two sets per benefit period	100%	Not Covered
Prophylaxis (cleaning) -- two per benefit period	100%	Not Covered
Fluoride Treatment – One treatment per benefit period, limited to dependents up to age 19	100%	Not Covered
Space Maintainers- limited to eligible dependents up to age 19	100%	Not Covered
Emergency Palliative Treatment – includes emergency oral exam	100%	Not Covered
Restorative Services		
Consultations and Other Exams by Specialist	85% after deductible	50% after deductible
Diagnostic X-Rays – including Full Mouth/Panorex, which are limited to one every 36 consecutive months	85% after deductible	50% after deductible
Amalgam Fillings	85% after deductible	50% after deductible
Resin Fillings -- Anterior and Posterior Surfaces	85% after deductible	50% after deductible
Endodontics/Pulp Services	85% after deductible	50% after deductible
Repairs, Relines & Adjustments of Prosthetics	85% after deductible	50% after deductible
Extractions	85% after deductible	50% after deductible
Impactions	85% after deductible	50% after deductible
Minor Oral Surgery Services	85% after deductible	50% after deductible
General Anesthesia	85% after deductible	50% after deductible
Complex Services		
Dental Implants	60% after deductible	30% after deductible
Gold Foil Restoration	60% after deductible	30% after deductible
Inlays, Onlays -- one every five years	60% after deductible	30% after deductible
Crowns – one every five years	60% after deductible	30% after deductible
Bridgework (Pontics & Abutments) – one every five years	60% after deductible	30% after deductible
Partial and Complete Dentures – one every five years	60% after deductible	30% after deductible
Periodontal Services[1]	60% after deductible	60% after deductible

Benefits	Network	Non-Network
Orthodontic Services		
Orthodontic Diagnostic Services	60% after deductible	60% after deductible
Minor Treatment for Tooth Guidance	60% after deductible	60% after deductible
Minor Treatment for Harmful Habits	60% after deductible	60% after deductible
Interceptive Orthodontic Treatment	60% after deductible	60% after deductible
Comprehensive Orthodontic Treatment	60% after deductible	60% after deductible

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

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[1] Services do not accumulate to the Benefit Period Maximum

g.

Vision Plan Design

Union Eye Care

Effective thru January 1, 2008

VISION CARE BENEFITS

SERVICES	FREQUENCY
A. Eye Examination	One every 12 months
B. Spectacle Lenses	One pair every 12 months
C. Frames	One every 12months
D. Contact Lenses	Allowance every 12 months in lieu of frame & eyeglass lenses

SERVICES PROVIDED

EYE EXAMINATIONS
Eye doctors are available at each location to serve a wide range of your eye care needs, from standard eyeglass lens exams and glaucoma checks, to specialized lens examinations and fittings. Please call for an appointment.

EYEGLASSES and CONTACT LENSES
Licensed opticians fill all of your eyewear prescription needs. They are trained for expert fitting of eyeglasses and contact lenses. No appointment is necessary if you have a prescription.

UNION EYE CARE NETWORK COVERAGE

Services provided to members through any Union Eye Care Center or affiliated location.

A. Vision Examination

1. Eye Examination eyeglasses includes glaucoma check & dilation when indicated	Full Coverage
2. Contact Lens Eye Exam	Full Coverage

B. Standard Spectacle Lenses (standard clear glass or plastic)

1. Single Vision	Full Coverage
2. Bifocals - standard lined	Full Coverage
3. Trifocals - standard lined	Full Coverage
4. Special Lenses Aphakic & Lenticular	Full Coverage
5. Tints 1, 2 or 3 solid color	Full Coverage
6. Photochromic - Glass	Full Coverage
7. High Index Polycarbonate	Full Coverage

C. Frame - Allowance $90.00

D. Contact Lenses Allowance
(in lieu of eyeglasses lenses & frame)

1. Therapeutic (medically necessary)	$300.00
2. Cosmetic Contacts	$100.00

E. Union Eye Care Network Discounts

1. Lens & Frame Products	20-45% Off MSRP
2. Lasik surgery discount through University Ophthalmologists	$300.00 Discount

HOW TO OBTAIN YOUR BENEFITS

If you need an eye examination, simply call any Union Eye Care location listed on the back of this brochure. Tell the receptionist that you are eligible for the **City of Parma's** vision benefit. **Please have the following information available.**

EMPLOYEE'S NAME and SSN
DEPENDENT'S NAME and DATE OF BIRTH

If you currently have a valid eyewear or contact lens prescription and wish to duplicate it, you will not need an appointment. Just bring your prescription to any Union Eye Care location to have it filled.

OUT-OF-NETWORK COVERAGE

If you elect to receive services from a doctor other than at Union Eye Care or an Network Affiliate facility, you will be reimbursed for the eye examination as follows:

A. Services	Max. Benefit Amount
1. Eye Examination	$ 50.00

OUT-OF-AREA COVERAGE

Coverage applies only when the eligible employee's permanent residence is more than thirty (30) miles (in radius) from a Union Eye Care or Network Affiliate facility.

A. Services	Max. Benefit Amount
1. Eye Examination	$ 50.00
2. Regular lenses (per pair)	
Single vision	$ 65.00
Bifocal	$ 75.00
Trifocal	$ 85.00
Special: Aphakic or Lenticular	$ 95.00
3. Frame only	$ 69.00
4. Contact lenses (in lieu of eyeglasses lenses & frame)	
a. Therapeutic (medically necessary) including professional fees	$150.00
b. Cosmetic, including professional fees	$75.00

OUT-OF-NETWORK COVERAGE

B. How To Obtain Your Reimbursement Claim Form

Reimbursement forms are available from your Human Resource Department, or you may call or write Union Eye Care to obtain a reimbursement claim form. The claim form must be completed by the employee and/or dependent, the doctor and the provider of materials.

C. Where To Submit Your Claim

Union Eye Care
Vision Plan Administrator
4750 Beidler Road
Willoughby, Ohio 44094

216-986-9700
800-443-9699
Fax: 216-986-1996

PROGRAM EXCLUSIONS

A. Lenses not requiring prescription

B. Glare Free or CRT coated lenses

C. Medical surgical treatment of eyes

D. Drugs or medication not administered for the purpose of a vision testing examination

E. Special or unusual procedures, such as orthoptics, perimetry, tonography, vision training, subnormal vision aids, aniseikonic disease or injury

F. Replacement of lost eyewear

G. Charges for rimless mounting, faceting or edge polishing

H. Charges for lenses of a type or style not listed

J. Contact lens examination fees to the extent that they exceed the plan benefit allowance

K. All taxes on materials or services