



SUPERMED PLUS 1000-2000-3000 PLANS



BASE PLAN	1000/3000	2000/6000	3000/9000
Network Benefit Period Deductible Single/Family (does not apply to Professional Services)	\$1,000/\$3,000	\$2,000/\$6,000	\$3,000/\$9,000
Non-Network Benefit Period Deductible Single/Family	\$2,000/\$6,000	\$4,000/\$12,000	\$6,000/\$18,000
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	N/A	N/A	N/A
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	\$4,000/\$12,000	\$8,000/\$24,000	\$12,000/\$36,000
Office Visit (OV) Copay Network/Non-Network	\$20 / \$40		
Urgent Care (UC) Copay Network/Non-Network	\$40 / \$60		
Coinsurance Network/Non-Network	100% / 80%		
Lifetime Maximum	\$2,500,000		

BENEFITS	PPO NETWORK	NON PPO NETWORK
Benefit Period	January 1 st through December 31 st	
Dependent Age Limit	19 Dependent, 23 Student; Removal upon End of the Month	
Physician/Office Services		
Office Visit (Illness/Injury)	\$20 copay, then 100%	\$40 copay, then 80%
Urgent Care Office Visit	\$40 copay, then 100%	\$60 copay, then 80%
All Immunizations	100%	50% after deductible ¹
Preventive Services		
Routine Physical Exam	\$20 copay, then 100%	50% after deductible ¹
Well Child Care Services to age nine. Well Child Exams & Immunizations are limited to a \$1,000 maximum per benefit period. Well Child Care Exams Well Child Immunizations Well Child Labs	\$20 copay, then 100% 100% 100% Professional Provider ² 100% after deductible, Facility Provider	80% after deductible
Routine Mammogram (one per benefit period)	100% Professional Provider ² 100% after deductible, Facility Provider	80% after deductible
Routine Pap Test (one per benefit period)	100% Professional Provider ² 100% after deductible, Facility Provider	80% after deductible
Routine PSA, Cholesterol, Colon Cancer Screening Tests, Bone Density Tests and Endoscopic Services	100% Professional Provider ² 100% after deductible, Facility Provider	80% after deductible
Routine EKG, Chest X-ray, Comprehensive Metabolic Panel, Urinalysis and Complete Blood Count (one each per benefit period)	100% Professional Provider ² 100% after deductible, Facility Provider	80% after deductible
Outpatient Services		
Allergy Testing and Treatments	100% after deductible	50% after deductible ¹
Physical & Occupational Therapies (40 visits per benefit period)	100% after deductible	80% after deductible
Speech Therapy (20 visits per benefit period)	100% after deductible	80% after deductible
Chiropractic Services (12 visits per benefit period)	100%	80% after deductible
Cardiac Rehabilitation (20 visits per benefit period)	100% after deductible	80% after deductible
Emergency Use of an Emergency Room	\$100 copay, then 100%	
Non-Emergency Use of an Emergency Room	\$100 copay, then 100%	\$100 copay, then 80%
Emergency Services	100%	
Surgical Services	100% after deductible	80% after deductible
Diagnostic Services	100% Professional Provider ² 100% after deductible, Facility Provider	80% after deductible



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BENEFITS	PPO NETWORK	NON PPO NETWORK
Inpatient Services		
Semi-Private Room and Board	100% after deductible	80% after deductible
Maternity	100% after deductible	80% after deductible
Skilled Nursing Facility (100 days per benefit period)	100% after deductible	80% after deductible
Additional Services		
Ambulance	\$50 copay, then 100%	\$50 copay, then 80%
Durable Medical Equipment	100% after deductible	80% after deductible
Home Health Care	100% after deductible	50% after deductible ¹
Hospice	100% after deductible	50% after deductible ¹
Organ and Tissue Transplants	100% after deductible	80% after deductible
Private Duty Nursing (\$1,000 maximum per benefit period)	100%	80% after deductible
Value Vision	Discount ³	None
Mental Health & 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% after deductible	50% after deductible ¹
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	\$20 copay, then 100%	\$40 copay, then 50% ¹
Prescription Drug – There are several different freestanding drug options available.		

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.

Deductible expenses incurred for services by a PPO Network provider will only apply to the PPO Network deductible. Deductible expenses incurred for services by a Non PPO Network provider will only apply to the Non PPO Network deductible.

Coinsurance expenses incurred for services by a PPO Network provider will only apply to the PPO Network coinsurance out-of-pocket limits. Coinsurance expenses incurred for services by a Non PPO Network provider will also apply to the PPO Network coinsurance out-of-pocket limits.

The coinsurance for non-contracting institutional providers will be the same coinsurance percentage as the Non PPO Network provider. However, you may be subject to balance billing by the non-contracting provider.

The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual case manager (except for corneal transplants.) Failure to contact the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

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

² Physician charge will pay at 80% for services not in a physician's office or independent lab.

³ A separate Value Vision discount program highlight sheet is available.