



SUPERMED ONE 1500



Benefits	Network	Non-Network
Benefit Period	January 1 st through December 31 st	
Dependent Age Limit	19 Dependent, 23 Student; Removal upon End of Month	
Lifetime Maximum	\$2,500,000	
Benefit Period Deductible – Single/Family	\$1,500/\$3,000	\$3,000/\$6,000
Coinsurance	80%	50%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	\$2,000/\$4,000	\$4,000/\$8,000
Physician/Office Services		
Office Visit (Illness/Injury)	\$25 copay, then 100%	50% after deductible
Urgent Care Office Visit	\$50 copay, then 100%	\$50 copay, then 100%
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	80% after deductible	50% after deductible ¹
Preventative Services		
Routine Physical Exam	\$25 copay, then 100%	50% after deductible ¹
Well Child Care services to age nine. Well child Exams & Well Child Immunizations are limited to a \$500 maximum per benefit period.		
Well Child Exam	\$25 copay, then 100%	50% after deductible ¹
Well Child Immunizations & Labs	80% after deductible	50% after deductible
Routine Mammogram (One per benefit period)	80% after deductible	50% after deductible
Routine Pap Test (One per benefit period)	80% after deductible	50% after deductible
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period)	80% after deductible	50% after deductible
Outpatient Services		
Allergy Testing and Treatments	80% after deductible	50% after deductible ¹
Diagnostic Services	80% after deductible	50% after deductible
Surgery	80% after deductible	50% after deductible
Physical Therapy (Institutional & Professional – 20 visits per benefit period)	\$25 copay, then 80%	50% after deductible
Occupational Therapy (Institutional & Professional – 20 visits per benefit period)	\$25 copay, then 80%	50% after deductible
Speech Therapy (Institutional & Professional – 20 visits per benefit period)	\$25 copay, then 80%	50% after deductible
Chiropractic Therapy (Professional Only – 12 visits per benefit period)	\$25 copay, then 80%	50% after deductible
Cardiac Rehabilitation (Institutional – 20 visits per benefit period)	80% after deductible	50% after deductible
Emergency use of an Emergency Room	80% after deductible	
Non-Emergency use of an Emergency Room	80% after deductible	50% after deductible
Inpatient Facility		
Semi-Private Room and Board	80% after deductible	50% after deductible
Skilled Nursing Facility (\$10,000 maximum per benefit period)	80% after deductible	50% after deductible
Additional Services		
Ambulance (\$300 Maximum per benefit period)	80% after deductible	80% after deductible
Durable Medical Equipment	80% after deductible	50% after deductible
Home Healthcare (60 visits per benefit period)	80% after deductible	50% after deductible ¹
Hospice	80% after deductible	50% after deductible ¹
Organ and Tissue Transplants ²	80% after deductible	50% after deductible
Value Vision	Discount ³	None

Benefits	Network	Non-Network
Mental Health and Substance Abuse		
Inpatient Mental Health/Substance Abuse Services: (30 days per benefit period; Substance Abuse limited to one admission per benefit period, three admissions per lifetime)	80% after deductible	50% after deductible ¹
Outpatient Mental Health/Substance Abuse Visits (20 visits per benefit period)	50% after deductible ¹	50% after deductible ¹
Prescription Drug – Oral Contraceptives Included		
Prescription Drug Benefit Period Deductible ⁴ (Single/Family)	\$250/\$500	\$250/\$500
Benefit period maximum	\$2,000 ⁵	
Retail – 30 Day Supply	80% after deductible	50% after deductible
Home Delivery – 90 Day Supply	80% after deductible	Not Covered
Optional Riders		
Maternity Rider		
Benefits are payable after 270 days of coverage under maternity rider, subject to a \$1,500 maternity deductible	80% after maternity deductible	50% after maternity deductible
Prescription Drug – Oral Contraceptives Included ⁶		
Retail – 30 Day Supply	\$15 Generic / \$30 Formulary / \$45 Non-Formulary	
Home Delivery – 90 Day Supply	\$30 Generic / \$60 Formulary / \$90 Non-Formulary	

Note: Deductible expenses incurred for services by a network provider will only apply to the network deductible. Deductible expenses incurred for services by a non-network provider will only apply to the non-network deductible.

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

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

This document is only a partial listing of benefits. This is not a contract of insurance. No person other than an officer of Medical Mutual may agree, 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 Coinsurance does not apply to out-of-pocket maximum. These services will not be covered at 100% once out of pocket maximum is met.
- ² The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual case manager (except for corneal transplants). Failure to contact Care Management prior to the proposed course of treatment (including the evaluation) will result in a \$5,000 penalty. There will be a \$10,000 non-network penalty for failure to use a SuperMed facility or a Non Designated Organ Transplant Network provider. This penalty may be waived by the Case Manager if the proper pre-determination procedures are followed.
- ³ A separate Value Vision discount program highlight sheet is available. If SuperMed Vision is purchased, Value Vision will be removed from the base benefit.
- ⁴ The prescription drug benefit period deductible includes deductibles paid for both retail and home delivery drugs.
- ⁵ The benefit period maximum is combined for both retail and mail order drugs.
- ⁶ Drug benefit contains the following:
 - Rx Selections® Drug List: A list of drugs on the Rx Selections® formulary will be used
 - Generic Incentive: If the member or physician requests a brand-name drug, and a generic equivalent exists, the member pays the generic co-payment PLUS the difference between the cost of the generic drug and the brand-name drug
 - Home Delivery Incentive: When a member chooses to fill a prescription a fourth time at a retail pharmacy within 180 days, the member will pay twice the normal retail co-payment