SuperMed One Short Term Plans

Base Plan	250	500	1000	1500
Network Benefit Period Deductible Single/Family	$250/$500	$500/$1,000	$1,000/$2,000	$1,500/$3,000
Non-Network Benefit Period Deductible Single/Family	$500/$1,000	$1,000/$2,000	$2,000/$4,000	$3,000/$6,000
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$5,000/$10,000			
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$10,000/$20,000			
Office Visit (OV) Copay	$25			
Urgent Care (UC) Copay	$25			
Coinsurance Network/Non-Network	80% / 50%			
Lifetime Maximum	$2,500,000			

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependent, 23 Student; Removal upon End of the Month	
Physician/Office Services		
Office Visit (Illness/Injury)	$25 copay, then 100%	$25 copay, then 50%
Urgent Care Office Visit	$25 copay, then 100%	$25 copay, then 50%
Standard Immunizations	80% after deductible	50% after deductible[1]
Preventive Services		
Well Child Care Services to age nine. Exams and Immunizations are limited to $500 per child to age one; thereafter, $150 per child per birth year to age nine) Well Child Care Exams, 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
Outpatient Services		
Allergy Testing and Treatments	80% after deductible	50% after deductible[1]
Physical Therapy (10 visits per benefit period)	80% after deductible	50% after deductible
Occupational Therapy (10 visits per benefit period)	80% after deductible	50% after deductible
Speech Therapy (10 visits per benefit period)	80% after deductible	50% after deductible
Chiropractic Services (10 visits per benefit period)	80% after deductible	50% after deductible
Cardiac Rehabilitation	80% after deductible	50% after deductible
Emergency Use of an Emergency Room	$100 copay, then 80%	
Non-Emergency Use of an Emergency Room	$100 copay, then 80%	$100 copay, then 50%
Surgical Services	80% after deductible	50% after deductible
Diagnostic Services	80% after deductible	50% after deductible
Inpatient Services		
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

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Benefits	Network	Non-Network
Additional Services		
Ambulance ($2,500 maximum per benefit period)	$100 copay, then 80%	
Durable Medical Equipment	80% after deductible	50% after deductible
Home Health Care (60 days per benefit period)	80% after deductible	50% after deductible[1]
Hospice	80% after deductible	50% after deductible[1]
Organ and Tissue Transplants	80% after deductible	50% after deductible
Value Vision	Discount[2]	None
Mental Health & Substance Abuse		
Inpatient Alcoholism (30 days per benefit period)	80% after deductible	50% after deductible[1]
Outpatient Alcoholism (20 visits per benefit period)	50% after deductible[1]	50% after deductible[1]
Prescription Drug – Oral Contraceptives Included		
Prescription Drug Benefit Period Deductible – Single/Family	$250/$500	
Prescription Drug Benefit Period Maximum	$500	
Retail – 30 Day Supply	80% after deductible	
Home Delivery – 90 Day Supply	NOT COVERED	

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 and coinsurance expenses incurred for services by a network provider will only apply to the network deductible and coinsurance out-of-pocket. 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.

The coinsurance for non-contracting institutional providers will be the same coinsurance percentage as the non-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 A separate Value Vision discount program highlight sheet is available.