



**COSE SUPERMED PLUS
1000-2000-3000 PLANS**



BASE PLAN	1000/3000	2000/6000	3000/9000
Network Benefit Period Deductible Single/Family	\$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		\$5,000,000	

BENEFITS	PPO NETWORK	NON PPO NETWORK
Benefit Period	January 1 st through December 31 st	
Dependent Age Limit	19 Dependent, 25 Student; Removal upon End of the Month	
Physician/Office Services		
Office Visit (Illness/Injury)	OV copay, then 100%	OV copay, then coinsurance
Urgent Care Office Visit	UC copay, then 100%	UC copay, then coinsurance
All Immunizations	100%	50% after deductible ¹
Preventive Services		
Routine Physical Exam	OV copay, then 100%	50% after deductible ¹
Well Child Care Services. Well Child Exams & Immunizations are limited to a \$1,000 maximum per benefit period.		
Well Child Care Exams	OV copay, then 100%	coinsurance after deductible
Well Child Immunizations	100%	
Well Child Labs	100%	
Routine Mammogram (one per benefit period)	100%	coinsurance after deductible
Routine Pap Test (one per benefit period)	100%	coinsurance after deductible
Routine PSA, Cholesterol, Colon Cancer Screening Tests, Bone Density Tests, Chlamydia Screening and Endoscopic Services	100%	coinsurance after deductible
Routine EKG, Chest X-ray, Comprehensive Metabolic Panel, Urinalysis and Complete Blood Count (one each per benefit period)	100%	coinsurance after deductible
Outpatient Services		
Allergy Testing and Treatments	coinsurance after deductible	50% after deductible ¹
Physical & Occupational Therapies (40 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Speech Therapy (20 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Chiropractic Services (12 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Cardiac Rehabilitation (24 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Emergency Use of an Emergency Room	\$150 copay, then network coinsurance	
Non-Emergency Use of an Emergency Room	\$150 copay, then coinsurance	\$150 copay, then coinsurance
Emergency Services	network coinsurance	
Surgical Services	coinsurance after deductible	coinsurance after deductible
Diagnostic Services (excluding MRI's and CT Scans)	100%	coinsurance after deductible
MRI's and CT Scans	coinsurance after deductible	coinsurance after deductible
Diagnostic Endoscopic Services	100%	coinsurance after deductible





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BENEFITS	PPO NETWORK	NON PPO NETWORK
Inpatient Services		
Semi-Private Room and Board	coinsurance after deductible	coinsurance after deductible
Maternity	coinsurance after deductible	coinsurance after deductible
Skilled Nursing Facility (100 days per benefit period)	coinsurance after deductible	coinsurance after deductible
Additional Services		
Ambulance	\$50 copay, then coinsurance	\$50 copay, then coinsurance
Durable Medical Equipment	coinsurance after deductible	coinsurance after deductible
Home Health Care	coinsurance after deductible	50% after deductible ¹
Hospice	coinsurance after deductible	50% after deductible ¹
Organ and Tissue Transplants	coinsurance after deductible	coinsurance after deductible
Private Duty Nursing (\$1,000 maximum per benefit period)	coinsurance after deductible	coinsurance after deductible
Diabetic Education and Training	100%	coinsurance after deductible
Routine Vision Exams	100%	coinsurance after deductible
Value Vision	Discount ²	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)	coinsurance after deductible	coinsurance after deductible
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	OV copay , then coinsurance after deductible	OV copay, then coinsurance after deductible
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 and coinsurance expenses incurred for services by a PPO Network provider will only apply to the PPO Network deductible and coinsurance out-of-pocket limits. Deductible and coinsurance expenses incurred for services by a Non PPO Network provider will only apply to the Non PPO Network deductible and 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.

No payment will be made for services related to a pre-existing condition for a period of 12 months for any condition treated or diagnosed within the six months immediately prior to the effective date of insurance.

HIPAA allows for crediting time a person was covered under a previous carrier if the previous coverage was continuous with not more than a 63 day gap in coverage prior to the effective date of the new coverage.

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.

