



## COSE SUPERMED PLUS 3000/9000 PLAN



| BASE PLAN   | 3000/9000         |
|---|-------------------|
| <b>Network Benefit Period Deductible</b> Single/Family                                    | \$3,000/\$9,000   |
| <b>Non-Network Benefit Period Deductible</b> Single/Family                                | \$6,000/\$18,000  |
| <b>Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible)</b> Single/Family     | N/A               |
| <b>Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible)</b> Single/Family | \$12,000/\$36,000 |
| <b>Office Visit (OV) Copay</b> Network/Non-Network  | \$20 / \$40       |
| <b>Urgent Care (UC) Copay</b> Network /Non-Network  | \$40 / \$60       |
| <b>Coinsurance</b> Network /Non-Network   | 100% / 80%        |
| <b>Lifetime Maximum</b>   | \$5,000,000       |

| BENEFITS   | PPO NETWORK   | NON PPO NETWORK                   |
|--|---|-----------------------------------|
| Benefit Period   | January 1 <sup>st</sup> through December 31 <sup>st</sup> |                                   |
| Dependent Age Limit  | 19 Dependent, 25 Student; Removal upon End of the Month   |                                   |
| <b>Physician/Office Services</b>   |   |                                   |
| 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 <sup>1</sup> |
| <b>Preventive Services</b>   |   |                                   |
| Routine Physical Exam  | OV copay, then 100%                                       | 50% after deductible <sup>1</sup> |
| 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      |
| <b>Outpatient Services</b>   |   |                                   |
| Allergy Testing and Treatments   | coinsurance after deductible                              | 50% after deductible <sup>1</sup> |
| 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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|---|--|---|
| <b>Inpatient Services</b>   |  |   |
| 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                |
| <b>Additional Services</b>  |  |   |
| 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 <sup>1</sup>           |
| Hospice   | coinsurance after deductible                 | 50% after deductible <sup>1</sup>           |
| 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 <sup>2</sup>                        | None  |
| <b>Mental Health &amp; Substance Abuse</b>  |  |   |
| 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 |
| <b>Prescription Drug – There are several different freestanding drug options available.</b>   |  |   |

*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.

<sup>1</sup> 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.

<sup>2</sup> A separate Value Vision discount program highlight sheet is available.