MEDICAL MUTUAL

M.C.S.E.I.C.
Core Plan

SuperMed PPO MEDICAL

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	26 – Removal upon End of Month	
Pre-Existing Condition Waiting Period **(does not apply to members under the age of 19)**	Initial Group Waived, All Others 6-9	
Blood Pint Deductible	No Deductible – 0 Pints	
Overall Annual Benefit Period Maximum	$2,500,000	
Benefit Period Deductible – Single/Family[1]	$250/$500	$500/$1,000
Coinsurance	90%	70%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	$400/$800	$1,000/$2,000
Out of Pocket Maximums if using network and participating providers	$650/$1,300	$1,500/$3,000
Physician/Office Services		
Office Visit (Illness/Injury)[2]	$10 copay, then 100%	70% after deductible
Urgent Care Office Visit[2]	$10 copay, then 100%	70% after deductible
Voluntary Second Surgical Opinion	90% after deductible	70% after deductible
All Immunizations & Injections[5]	90% after deductible	70% after deductible
Preventative Services		
Preventive Services, in accordance with federal law[4]		
Routine Physical Exams (Age 21 and over)	100%	70% after deductible
Well Child Care Services including Exam and Immunizations (To age 21)	100%	70% after deductible
Well Child Care Laboratory Tests (To age 21)	100%	70% after deductible
Routine Mammogram (One per benefit period)	100%	70% after deductible
Routine Pap Test (One per benefit period)	100%	70% after deductible
Routine PSA Test	100%	70% after deductible
Routine tests ordered by physician	100%	70% after deductible
Outpatient Services		
Surgical Services	90% after deductible	70% after deductible
Diagnostic Services	90% after deductible	70% after deductible
Dialysis Treatments	90% after deductible	70% after deductible
Physical Therapy - Facility and Professional (30 visits per benefit period) then subject to Medical Review	90% after deductible	70% after deductible
Occupational Therapy - (30 visits per benefit period) then subject to Medical Review – Facility & Professional	90% after deductible	70% after deductible
Chiropractic Therapy – Professional Only (36 visits per benefit period)	90% after deductible	70% after deductible
Speech Therapy – Facility and Professional (20 visits per benefit period) then subject to Medical Review	90% after deductible	70% after deductible
Radiation & Chemotherapy – includes Oral	90% after deductible	70% after deductible
Respiratory/Pulmonary Therapy	90% after deductible	70% after deductible
Cardiac Rehabilitation	90% after deductible	70% after deductible
Emergency & Non-Emergency use of an Emergency Room[3]	$50 copay, then 90% after deductible	

Benefits	Network	Non-Network
Inpatient Facility		
Semi-Private Room and Board	90% after deductible	70% after deductible
Maternity Services	90% after deductible	70% after deductible
Newborn Care	100%	70% after deductible
Skilled Nursing Facility (120 days per benefit period)	90% after deductible	70% after deductible
Additional Services		
Allergy Testing and Treatments	90% after deductible	70% after deductible
Ambulance Services – includes air if medically necessary	90% after deductible	
Durable Medical Equipment/Medical Supplies includes Jobst Stockings	90% after deductible	70% after deductible
Gastric Bypass Services & Follow-up - $30,000 Lifetime Maximum	90% after deductible	70% after deductible
Home Healthcare (90 visits per benefit period)	90% after deductible	70% after deductible
Hospice Services	90% after deductible	70% after deductible
Human Organ Transplant	90% after deductible	70% after deductible
Initial Newborn Exam	90% after deductible	70% after deductible
Private Duty Nursing ($5,000 maximum per benefit period)	90% after deductible	70% after deductible
Sterilization – No Reversals	90% after deductible	70% after deductible
TMJ - $500 Lifetime Maximum	90% after deducible	70% after deductible
Mental Health and Substance Abuse		
Inpatient Mental Health and Inpatient Substance Abuse Services	**Benefits paid are based on corresponding medical benefits**	
Outpatient Mental Health and Substance Abuse Services		

Note: Services requiring a copayment are not subject to the single/family deductible.

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

Non-Contracting and Facility Other Providers will pay the same as Non-Network.

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]Maximum family deductible. Member deductible is the same as single deductible. 3-month carryover applies.
[2]The office visit copay applies to the cost of the office visit only.
[3]Copay waived if admitted. The copay applies to room charges only. All other covered charges are subject to deductible.
[4]Preventive services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.
[5]Services are paid at percentage indicated unless it is a preventive service which includes evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.