MEDICAL MUTUAL®

SuperMed PPO

SuperMed® HSA 3500
Illustrative Summary of Benefits

Benefits	Network	Non-network
Benefit Period	Jan. 1 through Dec. 31	
Dependent Age Limit	Age 26 – Removal upon end of the month	
Deductible (Individual/Family)	$3,500/$7,000	$8,000/$16,000
Coinsurance Max. Out-of-Pocket (excluding deductible) (Individual/Family)	$0/$0	$8,000/$16,000
Maximum Out-of-Pocket (Individual/Family)[1]	$4,500/$9,000	$16,000/$32,000
Coinsurance (member cost)	0%	50%
Physician/Office Services		
Physician Office Visit	100% after deductible	50% after deductible
Specialist Office Visit	100% after deductible	50% after deductible
Urgent Care Office Visit	100% after deductible	50% after deductible
Emergency Services		
Emergency Use of an Emergency Room	100% after deductible	
Emergency Services (expenses other than Emergency Room)	100% after deductible	
Non-Emergency Use of an Emergency Room	Not covered	
Routine/Preventative Services[2]		
Health Care Reform Benefits	100%	50% after deductible
Health Care Reform Benefits for Women	100%	50% after deductible
All Immunizations	100%	50% after deductible
Routine Physical Exam (age 21 and over)	100%	50% after deductible
Routine Mammogram (one per benefit period)	100%	50% after deductible
Routine Pap Test (one per benefit period)	100%	50% after deductible
Routine Lab, Medical Tests and X-rays	100%	50% after deductible
Routine Endoscopic Services	100%	50% after deductible
Well Child Care (to age 21)		
Well Child Care Exams, Immunizations and Labs	100%	50% after deductible
Hearing Exams	100%	50% after deductible
Vision Exams	100%	50% after deductible
Outpatient Services		
Allergy Testing	100% after deductible	50% after deductible
Physical & Occupational Therapies (20 visits per benefit period)	100% after deductible	50% after deductible

Outpatient Services Continued	Network	Non-network
Speech Therapy (20 visits per benefit period)	100% after deductible	50% after deductible
Chiropractic Services (12 visits per benefit period)	100% after deductible	50% after deductible
Cardiac Rehabilitation (36 visits per benefit period)	100% after deductible	50% after deductible
Surgical Services (PCP-Physician Office)	100% after deductible	50% after deductible
Diagnostic Lab, Medical Tests and X-rays	100% after deductible	50% after deductible
Diagnostic Imaging	100% after deductible	50% after deductible
Diagnostic Endoscopic Services (PCP - Physician Office)	100% after deductible	50% after deductible
Inpatient Services		
Institutional Services	100% after deductible	50% after deductible
Maternity	100% after deductible	50% after deductible
Skilled Nursing Facility (90 days per benefit period)	100% after deductible	50% after deductible
Mental Health and Substance Abuse – Federal Mental Health Parity		
Inpatient Mental Health and Substance Abuse Services	Benefits paid are based on corresponding medical benefits.	
Outpatient Mental Health and Substance Abuse Services		

Prescription Drug Highlights	
Retail (30 day supply) - copay after deductible	Generic- $10 copay | Preferred- $35 copay | Non-Preferred- $60
Mail Order (90 day supply) - copay after deductible	Generic- $25 copay | Preferred- $87.50 copay | Non-Preferred- $150

[1]Network level out-of-pocket includes deductible and coinsurance and flat dollar copayments.

[2]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.

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

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.

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.

Total Monthly Premium
Employee Only $842.88
Employee + Spouse $1,857.43
Employee + Child(ren) $1,519.24
Family $2,533.79

Benefits will be administered by Medical Mutual of Ohio. 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. Only 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.