SuperMed One 2500, 3000 and 5000 HSA Plans

Base Plan	2500	3000	5000
Network Benefit Period Deductible Single/Family	$2,500/$5,000	$3,000/$6,000	$5,000/$10,000
Non-Network Benefit Period Deductible Single/Family	$5,000/$10,000	$6,000/$12,000	$10,000/$20,000
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/$8,000	$4,000/$8,000	$4,000/$8,000
Coinsurance Network/Non-Network	100% / 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)	100% after deductible	50% after deductible
Urgent Care Office Visit	100% after deductible	50% after deductible
Standard Immunizations	100% after deductible	50% after deductible
Preventive Services		
Routine Physical Exam	100% after deductible	50% after deductible
Well Child Care Services to age nine. Exams and Immunizations are limited to a $500 maximum per benefit period. Well Child Care Exams, Immunizations & Labs	100% after deductible	50% after deductible
Routine Mammogram (one per benefit period)	100% after deductible	50% after deductible
Routine Pap Test (one per benefit period)	100% after deductible	50% after deductible
Routine EKG, Chest X-ray, Comprehensive Metabolic Panel, Urinalysis and Complete Blood Count (one each per benefit period)	100% after deductible	50% after deductible
Outpatient Services		
Allergy Testing and Treatments	100% after deductible	50% after deductible
Physical Therapy (20 visits per benefit period)	100% after deductible	50% after deductible
Occupational Therapy (20 visits per benefit period)	100% after deductible	50% after deductible
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 (20 visits per benefit period)	100% after deductible	50% after deductible
Emergency Use of an Emergency Room	100% after deductible	
Non-Emergency Use of an Emergency Room	100% after deductible	50% after deductible
Surgical Services	100% after deductible	50% after deductible
Diagnostic Services	100% after deductible	50% after deductible
Inpatient Services		
Semi-Private Room and Board	100% after deductible	50% after deductible
Skilled Nursing Facility ($10,000 maximum per benefit period)	100% after deductible	50% after deductible
Benefits	Network	Non-Network
Additional Services		

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Ambulance ($2,500 maximum per benefit period)	100% after deductible	50% after deductible
Durable Medical Equipment	100% after deductible	50% after deductible
Home Health Care (60 days per benefit period)	100% after deductible	50% after deductible
Hospice	100% after deductible	50% after deductible
Organ and Tissue Transplants	100% after deductible	50% after deductible
Value Vision	Discount[1]	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)	100% after deductible	50% after deductible[2]
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	100% after deductible	50% after deductible[2]
Prescription Drug – Oral Contraceptives Included (Failure to present an ID card may result in increased cost.)		
Retail – 90 Day Supply Home Delivery – 90 Day Supply	100% after deductible	

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

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 A separate Value Vision discount program highlight sheet is available.

2Coinsurance 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.