MEDICAL MUTUAL OF OHIO
YOUR HEALTHCARE PARTNER SINCE 1934

SuperMed One Value Plans

SuperMed Plus

Base Plan	500	1000	1500
Network Benefit Period Deductible Single/Family	$500/$1,000	$1,000/$2,000	$1,500/$3,000
Non-Network Benefit Period Deductible Single/Family	$1,500/$3,000	$2,000/$4,000	$2,500/$5,000
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$3,500/$7,000	$4,000/$8,000	$4,500/$9,000
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$7,500/$15,000	$8,000/$16,000	$8,500/$17,000
Coinsurance Network/Non-Network	70% / 50%		
Lifetime Maximum	$7,500,000		

Benefits	PPO Network	Non-PPO Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	25 Dependent, 25 Student; Removal upon End of the Month	
Physician/Office Services		
Office Visit (Illness/Injury)	70% after deductible	50% after deductible
Urgent Care Office Visit	70% after deductible	50% after deductible
Standard Immunizations	70% after deductible	50% after deductible[1]
Preventive Services		
Routine Physical Exam	NOT COVERED	
Well Child Care Services to age nine. Exams and Immunizations are limited to $500 per child to age one; thereafter, $150 per child per birth year to age nine) Well Child Care Exams, Immunizations & Labs	70% after deductible	50% after deductible
Routine Mammogram (one per benefit period)	70% after deductible	50% after deductible
Routine Pap Test (one per benefit period)	70% after deductible	50% after deductible
Routine EKG, Chest X-ray, Comprehensive Metabolic Panel, Urinalysis and Complete Blood Count	NOT COVERED	
Outpatient Services		
Allergy Testing and Treatments	70% after deductible	50% after deductible[1]
Physical Therapy (10 visits per benefit period)	70% after deductible	50% after deductible
Occupational Therapy (10 visits per benefit period)	70% after deductible	50% after deductible
Speech Therapy (10 visits per benefit period)	70% after deductible	50% after deductible
Chiropractic Services (6 visits per benefit period)	70% after deductible	50% after deductible
Cardiac Rehabilitation	NOT COVERED	
Emergency Use of an Emergency Room	70% after deductible	
Non-Emergency Use of an Emergency Room	NOT COVERED	
Surgical Services	70% after deductible	50% after deductible
Diagnostic Services	70% after deductible	50% after deductible
Inpatient Services		
Semi-Private Room and Board	70% after deductible	50% after deductible
Skilled Nursing Facility ($10,000 maximum per benefit period)	70% after deductible	50% after deductible

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Benefits	PPO Network	Non-PPO Network
Additional Services		
Ambulance	70% after deductible	
Durable Medical Equipment	50% after deductible	50% after deductible
Home Health Care (60 days per benefit period)	70% after deductible	50% after deductible[1]
Hospice	70% after deductible	50% after deductible[1]
Organ and Tissue Transplants	70% after deductible	50% after deductible
Mental Health & Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (10 days per benefit period; Inpatient and Outpatient Substance Abuse limited to $550 per benefit period)	70% after deductible	50% after deductible[1]
Outpatient Mental Health and Substance Abuse Services 10 visits per benefit period; Inpatient and Outpatient Substance Abuse limited to $550 per benefit period)	50% after deductible[1]	50% after deductible[1]
Prescription Drug		
Prescription Drug Benefit Period Maximum	$500	
Prescription Drug Lifetime Maximum	$2,500,000	
Retail – 30 Day Supply	$15 copay – Generic drug only[2]	
Home Delivery – 90 Day Supply	NOT COVERED	

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

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 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 The prescription drug benefit does not cover brand-name prescriptions under any circumstance. This applies even if a brand name drug is medically necessary and a generic substitute is not available. This also applies even when your doctor writes "dispense as written" on your prescription.