



# SUPERMED ONE HSA<sup>1</sup> 3000



Benefits	In-Network	Out-of-Network
Benefit Period	January 1 <sup>st</sup> through December 31 <sup>st</sup>	
Dependent Age Limit	19 Dependent, 23 Student; Removal upon End of Month	
Lifetime Maximum	\$2,500,000	
Benefit Period Deductible — Single/Family	\$3,000/\$6,000	\$6,000/\$12,000
Coinsurance	100%	50%
Coinsurance Out-of-Pocket Maximum (Excludes Deductible) — Single/Family	N/A	\$4,000/\$8,000
<b>Physician/Office Services</b>		
Office Visit (Illness/Injury)	100% after deductible	50% after deductible
Urgent Care Office Visit	100% after deductible	50% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services.)	100% after deductible	50% after deductible
<b>Preventative Services</b>		
Routine Physical Exam	100% after deductible	50% after deductible
Well Child Care Services to age nine. Well Child Exams and Well Child Immunizations are limited to a \$500 maximum per benefit period		
Office Visit & Immunizations	100% after deductible	50% after deductible
Routine Mammogram (One per benefit period)	100% after deductible	50% after deductible
Routine Pap Smear (One per benefit period)	100% after deductible	50% after deductible
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period)	100% after deductible	50% after deductible
<b>Outpatient Services</b>		
Allergy Testing and Treatments	100% after deductible	50% after deductible
Diagnostic Services	100% after deductible	50% after deductible
Surgery	100% after deductible	50% after deductible
Physical Therapy (Institutional and Professional – 20 visits per benefit period)	100% after deductible	50% after deductible
Occupational Therapy (Institutional and Professional – 20 visits per benefit period)	100% after deductible	50% after deductible
Speech Therapy (Institutional and Professional – 20 visits per benefit period)	100% after deductible	50% after deductible
Chiropractic Therapy (Professional – 12 visits per benefit period)	100% after deductible	50% after deductible
Cardiac Rehabilitation (Institutional Only – 20 visits per benefit period)	100% after deductible	50% after deductible
Emergency Use of a Hospital Emergency Room	100% after deductible	100% after deductible
Non-Emergency Use of a Hospital Emergency Room	100% after deductible	50% after deductible
<b>Inpatient Facility</b>		
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
<b>Additional Services</b>		
Ambulance (\$2500 maximum per benefit period)	100% after deductible	50% after deductible
Durable Medical Equipment	100% after deductible	50% after deductible
Home Health Care (60 visits per benefit period)	100% after deductible	50% after deductible
Hospice	100% after deductible	50% after deductible
Organ and Tissue Transplants <sup>2</sup>	100% after deductible	50% after deductible
Value Vision	Discount <sup>3</sup>	None

Benefits	In-Network	Out-of-Network
<b>MENTAL HEALTH AND SUBSTANCE ABUSE</b>		
Inpatient Mental/Substance Abuse Services: (30 days per benefit period; Substance Abuse limited to one admission per benefit period and three admits per lifetime)	100% after deductible	50% <sup>4</sup> after deductible
Outpatient Mental/Substance Abuse Services: (20 visits per benefit period)	50% after deductible	50% <sup>4</sup> after deductible
<b>PRESCRIPTION DRUG – ORAL CONTRACEPTIVES INCLUDED</b>		
Retail — 90 Day Supply	100% after deductible	50% after deductible
Home Delivery — 90 Day Supply	100% after deductible	Not Covered

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

This document is not a contract of insurance. It is a partial listing of healthcare benefits. Refer to your certificate for a complete listing of healthcare benefits. Benefits are determined based on Medical Mutual of Ohio's medical and administrative policies and procedures.

No person other than an officer of Medical Mutual of Ohio 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 of Ohio's payment may not equal the percentage listed in these charts. However, the covered person's coinsurance will always be based on the lesser of the provider's billed charges or Medical Mutual of Ohio's negotiated rate with the provider.

<sup>1</sup> HSAs are the result of new legislation that is being continuously updated and revised. Consult with your tax advisor at the time you purchase your plan for guidance on the establishment and contribution levels of your HSA account.

<sup>2</sup> 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 Care Management prior to the proposed course of treatment (including the evaluation) will result in a \$5,000 penalty. There will be a \$10,000 non-network penalty for failure to use a SuperMed facility or a Non Designated Organ Transplant Network provider. This penalty may be waived by the Case Manager if the proper pre-determination procedures are followed.

<sup>3</sup> A separate Value Vision discount program highlight sheet is available. If SuperMed Vision is purchased, Value Vision will be removed from the base benefit.

<sup>4</sup> Coinsurance does not apply to out of pocket maximums. These services will not be covered at 100% once out-of-pocket maximum is met.