COSE BENEFIT PLAN

30-1,000 w/ Rx
Illustrative Summary of Benefits
Effective 1/1/2024

SuperMed Plus

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	26 - Removal upon End of the Month	
Deductible (Single / Family)	$1,000 / $3,000	$2,000 / $6,000
Coinsurance Max. Out-of-Pocket (excl. ded) (Single / Family)	N/A	$10,000 / $20,000
Maximum Out-of-Pocket (Single / Family)[1]	$6,600 / $13,200	$12,000 / $26,000
Coinsurance (member cost)	0%	50%
Physician/Office Services		
Physician Office Visit	$30 copay then 0%	coinsurance after deductible
Specialist Office Visit	$60 copay then 0%	coinsurance after deductible
Urgent Care Office Visit	$75 copay then 0%	coinsurance after deductible
Emergency Services		
Emergency Use of an Emergency Room	network coinsurance after $350 copay	
Emergency Services (expenses other than Emergency Room)	network coinsurance after deductible	
Non-Emergency Use of an Emergency Room	Not Covered	
Routine/Preventive Services[2]		
Health Care Reform Benefits	0%	coinsurance after deductible
Health Care Reform Benefits for Women	0%	coinsurance after deductible
All Immunizations	0%	coinsurance after deductible
Routine Physical Exam (age 21 and over)	0%	coinsurance after deductible
Routine Mammogram (one per benefit period)	0%	coinsurance after deductible
Routine Pap Test (one per benefit period)	0%	coinsurance after deductible
Routine Lab, Medical Tests, and X-rays	0%	coinsurance after deductible
Routine Endoscopic Services	0%	coinsurance after deductible
Well Child Care (to age 21)		
Well Child Care Exams, Immunizations and Labs	0%	coinsurance after deductible
Hearing Exams	0%	coinsurance after deductible
Vision Exams	0%	coinsurance after deductible
Lenses	Not Covered	Not Covered
Frames	Not Covered	Not Covered
Contacts	Not Covered	Not Covered
Outpatient Services		
Allergy Testing and Treatments	coinsurance after deductible	coinsurance after deductible
Physical & Occupational Therapies (40 visits per benefit period/combined)	coinsurance after deductible	coinsurance after deductible
Speech Therapy (20 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Chiropractic Services (12 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Cardiac Rehabilitation (36 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Surgical Services	coinsurance after deductible	coinsurance after deductible
Diagnostic Lab, Medical Tests, and X-rays	coinsurance after deductible	coinsurance after deductible
Diagnostic Imaging	coinsurance after deductible	coinsurance after deductible
Medically Necessary Colonoscopy, Sigmoidoscopy, Anoscopy and Proctosigmoidoscopy	0%	coinsurance after deductible
Inpatient Services		
Institutional Services	coinsurance after deductible	coinsurance after deductible
Maternity	coinsurance after deductible	coinsurance after deductible
Skilled Nursing Facility (90 days per benefit period)	coinsurance after deductible	coinsurance after deductible

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Benefits	Network	Non Network
Additional Services		
Ambulance	coinsurance after $50 copay	coinsurance after $50 copay
Autism Spectrum Disorders (benefits payable for the screening, diagnosis and treatment for Eligible Dependent children under the age of fourteen (14)).	Speech and language therapy: 20 visits per Benefit Period Occupational Therapy: 20 visits per Benefit Period Clinical therapeutic intervention: 20 hours per week	coinsurance after deductible
Diabetic Education and Training	coinsurance after deductible, unless the service is covered under Health Care Reform Preventive Benefits	coinsurance after deductible
Durable Medical Equipment	coinsurance after deductible	coinsurance after deductible
DME - Wigs	Not Covered	Not Covered
Home Health Care (100 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Hospice	coinsurance after deductible	coinsurance after deductible
Organ and Tissue Transplants	coinsurance after deductible	coinsurance after deductible
Organ Transplant Services (includes travel, meals, lodging and transportation)	Not Covered	Not Covered
Private Duty Nursing (90 days per benefit period)	coinsurance after deductible	coinsurance after deductible
Sterilization	coinsurance after deductible	coinsurance after deductible
Mental Health & 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 Benefits[3]		
Network Pharmacy / Retail (30 day supply)	Generic: $15 copay; Preferred Brand: $45 copay; Non-Preferred Brand: $75 copay; Specialty High-Cost Drugs: $275 copay	
Home Delivery / Contracted Provider (90 day supply) (Specialty drugs limited to 30 day supply)	Generic: $45 copay; Preferred Brand: $135 copay; Non-Preferred Brand: $225 copay; Specialty High-Cost Drugs: $275 copay	

[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.

[3]**Generic Incentive** - Brand copay + price difference between brand and generic; Will not apply to MOOP.
Home Delivery Incentive Home Delivery Incentive Retail drug copays apply for the first three fills in 180 days. Starting on the 4th fill, copay amount doubles unless mail order is used.
Specialty Drugs - Drugs and biologicals (specialty drugs and therapeutic injections). Members must use one of our contracted specialty pharmacies. Special rules apply to oral chemotherapy prescription drugs. The certificate booklet will have more information. Certain specialty drugs are part of a Specialty Prescription Drug Copay Offset program (SaveOn) where they are considered non-essential health benefits and therefore do not apply to the out-of-pocket maximum. They will also be subject to higher cost-share if the member does not participate in SaveOn. Once enrolled in the Medical Mutual health plan, call 1-800-683-1074 to enroll in copay assistance, with SaveOnSP monitoring, so that your responsibility could be as low as $0

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.

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.