



North Point Educational Service Center
 a member of
**Huron-Erie School Employee
 Insurance Association**
SuperMed Plus



Benefits	Network	Non-Network
Benefit Period	January 1 st through December 31 st	
Dependent Age Limit	19 Dependent / 25 Student Removal upon End of Month	
Blood Pint Deductible	0 pints	
Lifetime Maximum	\$2,000,000	
Benefit Period Deductible – Single/Family ¹	\$500 / \$1,000	\$500 / \$1,000
Coinsurance	90%	80%
Coinsurance Maximum - Single/Family ¹	\$500 / \$1,000	\$1,000 / \$2,000
Coinsurance Out-of-Pocket Maximum (Including Deductible) – Single/Family	\$1,000 / \$2,000	\$1,500 / \$3,000
Physician/Office Services		
Office Visit (Illness/Injury) ²	\$20 copay, then 100%	\$20 copay, then 80%
Urgent Care Office Visit ²	\$20 copay, then 100%	\$20 copay, then 80%
Routine Services		
Routine Physical Exams (Ages nine and over) ²	\$20 copay, then 100%	\$20 copay, then 80%
Well Child Care Services including Exam, Immunizations and Laboratory Tests (Birth to age nine, limited to a \$500 maximum per benefit period) ²	Exam - \$20 copay, then 100% Immunizations/Labs – 90% - Not subject to deductible	\$20 copay, then 80% Immunizations/Labs – 80% - Not subject to deductible
Routine Mammogram (One per benefit period)	90% not subject to deductible	80% not subject to deductible
Routine Pap Test (One per benefit period)	90% not subject to deductible	80% not subject to deductible
Routine Prostate Specific Antigen (PSA)	90% not subject to deductible	80% not subject to deductible
Routine Endoscopies	90% not subject to deductible	80% not subject to deductible
All Routine X-rays, Medical Tests and Laboratory Tests (Ages nine and over)	90% not subject to deductible	80% not subject to deductible
Outpatient Services		
Surgical Services	90% after deductible	80% after deductible
Diagnostic Services	90% after deductible	80% after deductible
Physical & Occupational Therapy - Facility and Professional (40 visits combined per benefit period)	90% after deductible	80% after deductible
Chiropractic Therapy – Professional Only (12 visits per benefit period)	50% after deductible	50% after deductible
Speech Therapy – Facility and Professional (20 visits per benefit period)	90% after deductible	80% after deductible
Cardiac Rehabilitation	90% after deductible	80% after deductible
Emergency use of an Emergency Room ³	\$75 copay, then 100%	
Non-Emergency use of an Emergency Room ⁴	\$75 copay, then 90%	\$75 copay, then 80%

Benefits	Network	Non-Network
Inpatient Facility		
Semi-Private Room and Board – Including Ancillaries (365 days per in-hospital benefit period ⁵)	90% after deductible	80% after deductible
Maternity	90% after deductible	80% after deductible
Skilled Nursing Facility (Two days available for each unused in-hospital day)	90% after deductible	80% after deductible
Human Organ Transplants	90% after deductible	80% after deductible
Additional Services		
Allergy Testing and Treatments	90% after deductible	80% after deductible
Ambulance – air if medically necessary	90% after deductible	80% after deductible
Durable Medical Equipment	90% after deductible	80% after deductible
Home Healthcare	90% after deductible	80% after deductible
Hospice Services	90% after deductible	80% after deductible
Private Duty Nursing	90% after deductible	80% after deductible
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (31 days per benefit period; Substance Abuse limited to 3 admissions per Lifetime)	90% after deductible	80% after deductible
Outpatient Mental Health and Substance Abuse Services (50 visits per benefit period)	50% after deductible	50% after deductible

Note: Services requiring a copayment are not subject to the single/family deductible.

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

Non-Contracting and Facility Other Providers will pay the same as Non-Network.

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.

¹Maximum family deductible. Member deductible is the same as single deductible. 4th quarter carryover applies.

²The office visit copay applies to the cost of the office visit only.

³Copay waived if admitted. The copay applies to room charges only. All other covered charges are not subject to deductible.

⁴Copay waived if admitted. The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance.

⁵An in-hospital benefit period is a period of time beginning when the member enters a hospital and ending when he/she has been out for 90 consecutive days.