Dentist's Choice Health Care Plans
SuperMed Plus HSA 2000-3000
11/01/11

Base Plan	2000	3000
Benefit Period Deductible – Non-embedded [1]	$2,000 Single Contract $4,000 Family Contract	$3,000 Single Contract $6,000 Family Contract

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	26/28 Removal upon Birthday	
Lifetime Maximum	$2,500,000	
Coinsurance	80%	60%
Coinsurance Out-of-Pocket Maximum[2] (Excluding Deductible) – Single/Family	$3,000 Single Contract $6,000 Family Contract	$6,000 Single Contract $12,000 Family Contract
Physician/Office Services		
Office Visit (Illness/Injury)	80% after deductible	60% after deductible
Urgent Care Office Visit	80% after deductible	60% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	100%	60% after deductible
Preventative Services		
Preventive Services, in accordance with state and federal law[3]	100%	60% after deductible
Routine Physical Exam (21 and over)	100%	60% after deductible
Well Child Care Services including Exam, Routine Vision, Routine Hearing Exams, Well Child Care Immunizations and Laboratory (To age 21)	100%	60% after deductible
Routine Colorectal Screening and Endoscopic Services (all ages)	100%	60% after deductible
Routine Mammogram (all ages, one per benefit period)	100%	60% after deductible
Routine Pap Test (all ages, one per benefit period)	100%	60% after deductible
Routine Prostate Specific Antigen (PSA) (all ages)	100%	60% after deductible
Routine Vision Exam (21 and over, one per benefit period)	80% after deductible	60% after deductible
Routine Chest X-Ray, EKG, Complete Metabolic Panel, Urine Analysis, Complete Blood Count (all ages, one per benefit period)	100%	60% after deductible
Outpatient Services		
Surgical Services	80% after deductible	60% after deductible
Diagnostic Services	80% after deductible	60% after deductible
Cardiac Rehabilitation –Facility only (20 visits per benefit period)	80% after deductible	60% after deductible
Physical/Occupational Therapy - Facility and Professional (40 visits per benefit period)	80% after deductible	60% after deductible
Chiropractic Services – Facility and Professional (12 visits per benefit period)	80% after deductible	60% after deductible
Speech Therapy – Facility and Professional (20 visits per benefit period)	80% after deductible	60% after deductible

Benefits	Network	Non-Network
Emergency use of an Emergency Room	80% after deductible	
Non-Emergency use of an Emergency Room	80% after deductible	60% after deductible
Inpatient Facility		
Semi-Private Room and Board	80% after deductible	60% after deductible
Maternity	80% after deductible	60% after deductible
Skilled Nursing Facility (100 days per benefit period)	80% after deductible	60% after deductible
Additional Services		
Allergy Testing and Treatments	80% after deductible	60% after deductible
Ambulance	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Home Healthcare	80% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible
Organ Transplants[4]	80% after deductible	60% after deductible
Prescriptions Drugs (oral contraceptives covered)	80% after deductible 30 day-supply	
Private Duty Nursing ($1,000 maximum per benefit period)	80% after deductible	60% after deductible
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services	**Benefits paid are based on corresponding medical benefits**.	
Outpatient Mental Health and Substance Abuse Services		

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 facilities will pay 70% of the normal contract reimbursement. The 30% will not accumulate toward any Coinsurance Out-of-Pocket Maximums. Non-Contracting Facility Other Providers will pay at 50%. The 50% will not accumulate toward any Coinsurance Out-of-Pocket-Maximums.

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.

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[1] Non-embedded deductible - Family deductible must be met before benefits are provided on a family contract.

[2] Family coinsurance out-of-pocket maximum. Family coinsurance must be met before benefits are provided at the highest level on a family contract.

[3] 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.

[4] 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 the United Resource Network. This penalty may be waived by the Case Manager if the proper pre-determination procedures are followed