MEDICAL MUTUAL™

Dentist's Choice Health Care Plans
SuperMed Plus 250 – 500 – 750 - 1000
11/01/11

SuperMed Plus®

Base Plan	250/500	500/1000	750/1500	1000/2000
Benefit Period Deductible – Single/Family[1]	$250/$500	$500/$1,000	$750/$1,500	$1,000/$2,000
Office Visit (OV) Copay[2] Network	$20	$25	$25	$30
Specialty Visit (SV) Copay[2] Network	$30	$35	$35	$40
Urgent Care Office Visit[2] Network	$20	$25	$25	$30
Coinsurance Out-of Pocket Maximum NETWORK (Excluding Deductible) – Single/Family	$2,000/$4,000	$2,500/$5,000	$2,500/$5,000	$3,000/$6,000
Coinsurance Out-of Pocket Maximum NON-NETWORK (Excluding Deductible) – Single/Family	$4,000/$8,000	$5,000/$10,000	$5,000/$10,000	$6,000/$12,000

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%	64%
Physician/Office Services		
Office Visit (Illness/Injury) [2]	OV copay, then 100%	64% after deductible
Specialty Visit (Illness/Injury) [2]	SV copay, then 100%	64% after deductible
Urgent Care Office Visit[2]	UC copay, then 100%	64% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	100%	64% after deductible
Preventative Services		
Preventative Services, in accordance with state and federal law[3]	100%	80% after deductible
Routine Physical Exam (Age 21 and over)	100%	80% after deductible
Well Child Care Services including Exam, Routine Vision, Routine Hearing Exams, Well Child Care Immunizations and Laboratory (To age 21)	100%	80% after deductible
Routine Colorectal Cancer Screening and Endoscopic Services (all ages)	100%	80% after deductible
Routine Mammogram (all ages, one per benefit period)	100%	80% after deductible
Routine Pap Test (all ages, one per benefit period)	100%	80% after deductible
Routine Prostate Specific Antigen (PSA) (all ages)	100%	80% after deductible
Routine Vision Exam (21 and over, one per benefit period)	OV copay, then 100%	80% after deductible
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (21 and over, one each per benefit period)	100%	80% after deductible
Prescription Services – See Attached Prescription Drug Card Program Description		
Outpatient Services		
Surgical Services	80% after deductible	64% after deductible
Diagnostic Services	80% after deductible	64% after deductible
Physical Therapy/Occupational Therapy - Facility and Professional (40 visits per benefit period)	80% after deductible	64% after deductible
Chiropractic Therapy – Professional Only (12 visits per benefit period)	80% after deductible	64% after deductible

Benefits	Network	Non-Network
Speech Therapy – Facility and Professional (20 visits per benefit period)	80% after deductible	64% after deductible
Cardiac Rehabilitation (20 visits per benefit period)	80% after deductible	64% after deductible
Emergency use of an Emergency Room[4]	$250 copay, then 80%	
Non-Emergency use of an Emergency Room [4]	$250 copay, then 80%	$250 copay, then 64%
Inpatient Facility		
Semi-Private Room and Board	80% after deductible	64% after deductible
Maternity	80% after deductible	64% after deductible
Skilled Nursing Facility	80% after deductible	64% after deductible
Additional Services		
Allergy Testing and Treatments	80% after deductible	64% after deductible
Ambulance	80% after deductible	64% after deductible
Durable Medical Equipment	80% after deductible	64% after deductible
Home Healthcare	80% after deductible	64% after deductible
Hospice	80% after deductible	64% after deductible
Organ Transplants	80% after deductible	64% after deductible
Private Duty Nursing ($5,000 maximum per benefit period)	80% after deductible	64% 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 expenses incurred for services by a non-network provider will also apply to the network deductible out-of-pocket limits. Deductible expenses incurred for services by a network provider will also apply to the non-network deductible out-of pocket limits.

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

[1]Maximum family deductible. Member deductible is the same as single deductible. 3-month carryover applies.
[2]The office visit copay applies to the cost of the office visit only.
[3]Preventative 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]Copay waived if admitted. The copay applies to room charges only. All other covered charges are subject to deductible.

Dentist's Choice Health Care Plans
SuperMed® Script[1]
Prescription Drug Program
11/1/11

Benefits	Copay	Day Supply
Benefit Period	January 1st through December 31st	
Dependent Age Limit	Same as Medical	
SuperMed Script Program with Oral Contraceptive Coverage – for the initial filling and up to two refills of the same prescription drug at a retail pharmacy, your copay is:		
Generic Copayment	$15	30
Formulary Copayment	$30	30
Non-Formulary Copayment	$50	30
SuperMed Script Program with Oral Contraceptive Coverage – after the third fill of the same prescription drug at a retail pharmacy, your copay is:		
Generic Copayment	$45	30
Formulary Copayment	$90	30
Non-Formulary Copayment	$150	30
SuperMed Script Home Delivery Program with Oral Contraceptive Coverage		
Generic Copayment	$45	90
Formulary Copayment	$90	90
Non-Formulary Copayment	$150	90

Note: In an effort to continue our commitment to quality care and help contain the increasing cost of prescription drug coverage, a formulary feature is included in your prescription drug benefit. A formulary drug is a FDA approved prescription medication reviewed by an independent Pharmacy and Therapeutics Committee brought together by Medco Health Solutions, Inc. Formulary drugs can assist in maintaining quality care while meeting your plan's cost containment objectives.

Benefits will be determined based on Medical Mutual's medical and administrative policies and procedures.

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[1]SuperMed Script contains the following:

- Rx Selections® Drug List: A list of drugs on the Rx Selections® formulary will be used.
- Generic Incentive: If the member or physician requests a brand-name drug and a generic equivalent exists, the member pays the generic copayment PLUS the difference between the cost of the generic drug and the brand-name drug.
- Home Delivery Incentive: When a member chooses to fill a prescription a fourth time at a retail pharmacy within 180 days, the member will pay three times the normal retail copayment.