



Dentist's Choice Health Care Alliance
SuperMed® Script¹
Prescription Drug Program
08/01/09

Benefits	Co-pay	Day Supply
Benefit Period	January 1 st through December 31 st	
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.

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.

¹SuperMed 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.



Dentist's Choice Health Care Alliance
Medifil
365 Day and Supplemental
Major Medical Coverage

Benefit Period: Calendar Year

Part A Benefits	Part B Benefits
<p><u>Hospital Stays</u></p> <p>Benefits include days of a hospital stay during a Medicare benefit period in a hospital that contracts with either Medical Mutual or Medicare.</p> <p>Medical Mutual pays for 365 days of stay per in-hospital benefit period:</p> <ul style="list-style-type: none"> When Medicare pays a portion of the stay, we will pay the Part A Medicare eligible expenses not paid by Medicare. After all of the hospital days of stay available from Medicare have been exhausted, we will pay 100% of the provider's reasonable charge to a contracting hospital for any remaining days. We will pay 70% of the charges to a non-contracting hospital. <p><u>Skilled Nursing Facility</u></p> <p>Medical Mutual pays 100 days of stay per Medicare benefit period.</p> <ul style="list-style-type: none"> When Medicare pays a portion of such a stay, we will pay the Part A Medicare eligible expenses not paid by Medicare. <p><u>Outpatient Care for Mental Illness, Drug Abuse and Alcoholism</u></p> <p>This benefit is limited to \$1,100 per calendar year.</p>	<p>Medical Mutual pays the Medicare Part B deductible.</p> <p>After the Medicare Part B deductible:</p> <ul style="list-style-type: none"> If the provider accepts Medicare assignment, we pay the coinsurance amount for Part B Medicare eligible expenses. If the provider does not accept Medicare assignment, we pay the provider's reasonable charge or the Medicare reasonable charge, whichever is higher, minus the amount paid by Medicare. <p><u>Medical Care Received While Traveling Outside of the United States</u></p> <p>For services or supplies determined Part B, Medicare-eligible expenses: 100% of the provider's reasonable charge.</p> <p><u>Supplemental Major Medical</u></p> <p>Lifetime Maximum\$250,000</p> <p>Deductible Per Calendar Year\$100</p> <p>Coinsurance80% after deductible</p> <p>Office Visits (definite condition or injury)80%</p> <p>Outpatient Mental Illness, drug Abuse and Alcoholism: 50% up to \$1,000 per calendar year</p>

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.



**Dentist's Choice Health Care Alliance
SuperMed Plus 250/500
08/01/09**



Benefits	Network	Non-Network
Benefit Period	January 1 st through December 31 st	
Dependent Age Limit	24 th Birthday	
Lifetime Maximum	\$2,500,000	
Benefit Period Deductible – Single/Family ¹	\$250 / \$500	
Coinsurance	80%	64%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	\$2,000 / \$4,000	\$4,000 / \$8,000
Physician/Office Services		
Office Visit (Illness/Injury) ²	\$20 copay, then 100%	80% after deductible
Urgent Care Office Visit ²	\$20 copay, then 100%	80% after deductible
Voluntary Second Surgical Opinion	80% after deductible	64% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	80% after deductible	64% after deductible
Preventative Services		
Routine Physical Exam (Ages nine and over) ²	\$20 copay, then 100%	80% after deductible
Well Child Care Services including Exam and Immunizations (To age nine, limited to a \$1,000 maximum per benefit period) ²	\$20 copay, then 100%	80% after deductible
Well Child Care Laboratory Tests (To age nine)	100%	80% after deductible
Routine Colorectal Cancer Screening and Endoscopic Services (Over age 50)	100%	80% after deductible
Routine Mammogram (One per benefit period)	100%	80% after deductible
Routine Pap Test (One per benefit period)	100%	80% after deductible
Routine Vision Exam (One per benefit period)	\$20 copay, then 100%	80% after deductible
Routine Prostate Specific Antigen (PSA)	100%	80% after deductible
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (Ages nine and over, one each per benefit period)	100%	80% after deductible
Outpatient Services		
Surgical Services	80% after deductible	64% after deductible
Diagnostic Services	80% after deductible	64% after deductible
Physical/Chiropractic Therapy - Facility and Professional (10 visits then subject to Medical Review)	80% after deductible	64% after deductible
Speech Therapy – Facility and Professional (10 visits then subject to Medical Review)	80% after deductible	64% after deductible
Emergency use of an Emergency Room ³	\$100 copay, then 80%	
Non-Emergency use of an Emergency Room ³	\$100 copay, then 80%	\$100 copay, then 64%

Benefits	Network	Non-Network
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 (22 days per benefit period)	80% after deductible	64% after deductible
Outpatient Mental Health Services (20 visits per benefit period)	80% after deductible	64% after deductible
Outpatient Substance Abuse Services (20 visits per benefit period)	80% after deductible	64% 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. 3-month 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 subject to deductible.



Dentist's Choice Health Care Alliance
SuperMed Plus 500/1000
08/01/09



Benefits	Network	Non-Network
Benefit Period	January 1 st through December 31 st	
Dependent Age Limit	24 th Birthday	
Lifetime Maximum	\$2,500,000	
Benefit Period Deductible – Single/Family ¹	\$500 / 1,000	
Coinsurance	80%	64%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	\$2,000 / \$4,000	\$4,000 / \$8,000
Physician/Office Services		
Office Visit (Illness/Injury) ²	\$25 copay, then 100%	80% after deductible
Urgent Care Office Visit ²	\$25 copay, then 100%	80% after deductible
Voluntary Second Surgical Opinion	80% after deductible	64% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	80% after deductible	64% after deductible
Preventative Services		
Routine Physical Exam (Ages nine and over) ²	\$25 copay, then 100%	80% after deductible
Well Child Care Services including Exam and Immunizations (To age nine, limited to a \$1,000 maximum per benefit period) ²	\$25 copay, then 100%	80% after deductible
Well Child Care Laboratory Tests (To age nine)	100%	80% after deductible
Routine Colorectal Cancer Screening and Endoscopic Services (Over age 50)	100%	80% after deductible
Routine Mammogram (One per benefit period)	100%	80% after deductible
Routine Pap Test (One per benefit period)	100%	80% after deductible
Routine Prostate Specific Antigen (PSA)	100%	80% after deductible
Routine Vision Exam (one per benefit period)	\$25 copay, then 100%	80% after deductible
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (Ages nine and over, one each per benefit period)	100%	80% after deductible
Outpatient Services		
Surgical Services	80% after deductible	64% after deductible
Diagnostic Services	80% after deductible	64% after deductible
Physical/Chiropractic Therapy - Facility and Professional (10 visits then subject to Medical Review)	80% after deductible	64% after deductible
Speech Therapy – Facility and Professional (10 visits then subject to Medical Review)	80% after deductible	64% after deductible
Emergency use of an Emergency Room ³	\$100 copay, then 80%	
Non-Emergency use of an Emergency Room ³	\$100 copay, then 80%	\$100 copay, then 64%

Benefits	Network	Non-Network
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 (22 days per benefit period)	80% after deductible	64% after deductible
Outpatient Mental Health Services (20 visits per benefit period)	80% after deductible	64% after deductible
Outpatient Substance Abuse Services (20 visits per benefit period)	80% after deductible	64% after deductible

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.

¹Maximum family deductible. Member deductible is the same as single deductible. 3-month 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 subject to deductible.



Dentist's Choice Health Care Alliance
SuperMed Plus 750/1500
08/01/09



Benefits	Network	Non-Network
Benefit Period	January 1 st through December 31 st	
Dependent Age Limit	24 th Birthday	
Lifetime Maximum	\$2,500,000	
Benefit Period Deductible – Single/Family ¹	\$750 / 1,500	
Coinsurance	80%	64%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	\$2,000 / \$4,000	\$4,000 / \$8,000
Physician/Office Services		
Office Visit (Illness/Injury) ²	\$25 copay, then 100%	80% after deductible
Urgent Care Office Visit ²	\$25 copay, then 100%	80% after deductible
Voluntary Second Surgical Opinion	80% after deductible	64% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	80% after deductible	64% after deductible
Preventative Services		
Routine Physical Exam (Ages nine and over) ²	\$25 copay, then 100%	80% after deductible
Well Child Care Services including Exam and Immunizations (To age nine, limited to a \$1,000 maximum per benefit period) ²	\$25 copay, then 100%	80% after deductible
Well Child Care Laboratory Tests (To age nine)	100%	80% after deductible
Routine Colorectal Cancer Screening and Endoscopic Services (Over age 50)	100%	80% after deductible
Routine Mammogram (One per benefit period)	100%	80% after deductible
Routine Pap Test (One per benefit period)	100%	80% after deductible
Routine Prostate Specific Antigen (PSA)	100%	80% after deductible
Routine Vision Exam (one per benefit period)	\$25 copay, then 100%	80% after deductible
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (Ages nine and over, one each per benefit period)	100%	80% after deductible
Outpatient Services		
Surgical Services	80% after deductible	64% after deductible
Diagnostic Services	80% after deductible	64% after deductible
Physical/Chiropractic Therapy - Facility and Professional (10 visits then subject to Medical Review)	80% after deductible	64% after deductible
Speech Therapy – Facility and Professional (10 visits then subject to Medical Review)	80% after deductible	64% after deductible
Emergency use of an Emergency Room ³	\$100 copay, then 80%	
Non-Emergency use of an Emergency Room ³	\$100 copay, then 80%	\$100 copay, then 64%

Benefits	Network	Non-Network
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 (22 days per benefit period)	80% after deductible	64% after deductible
Outpatient Mental Health Services (20 visits per benefit period)	80% after deductible	64% after deductible
Outpatient Substance Abuse Services (20 visits per benefit period)	80% after deductible	64% after deductible

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.

¹Maximum family deductible. Member deductible is the same as single deductible. 3-month 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 subject to deductible.



**Dentist's Choice Health Care Alliance
SuperMed Plus 1000/2000
08/01/09**



Benefits	Network	Non-Network
Benefit Period	January 1 st through December 31 st	
Dependent Age Limit	24 th Birthday	
Lifetime Maximum	\$2,500,000	
Benefit Period Deductible – Single/Family ¹	\$1,000 / \$2,000	
Coinsurance	80%	64%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	\$2,000 / \$4,000	\$4,000 / \$8,000
Physician/Office Services		
Office Visit (Illness/Injury) ²	\$30 copay, then 100%	80% after deductible
Urgent Care Office Visit ²	\$30 copay, then 100%	80% after deductible
Voluntary Second Surgical Opinion	80% after deductible	64% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	80% after deductible	64% after deductible
Preventative Services		
Routine Physical Exam (ages nine and over) ²	\$30 copay, then 100%	80% after deductible
Well Child Care Services including Exam and Immunizations (To age nine, limited to a \$1,000 maximum per benefit period) ²	\$30 copay, then 100%	80% after deductible
Well Child Care Laboratory Tests (To age nine)	100%	80% after deductible
Routine Colorectal Cancer Screening and Endoscopic (Over age 50)	100%	80% after deductible
Routine Mammogram (One per benefit period)	100%	80% after deductible
Routine Pap Test (One per benefit period)	100%	80% after deductible
Routine Prostate Specific Antigen (PSA)	100%	80% after deductible
Routine Vision Exam (One per benefit period)	\$30 copay, then 100%	80% after deductible
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (Ages nine and over, one each per benefit period)	100%	80% after deductible
Outpatient Services		
Surgical Services	80% after deductible	64% after deductible
Diagnostic Services	80% after deductible	64% after deductible
Physical/Chiropractic Therapy - Facility and Professional (10 visits then subject to Medical Review)	80% after deductible	64% after deductible
Speech Therapy – Facility and Professional (10 visits then subject to Medical Review)	80% after deductible	64% after deductible
Emergency use of an Emergency Room ³	\$100 copay then 80%	
Non-Emergency use of an Emergency Room ³	\$100 copay, then 80%	\$100 copay, then 64%

Benefits	Network	Non-Network
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 (22 days per benefit period)	80% after deductible	64% after deductible
Outpatient Mental Health Services (20 visits per benefit period)	80% after deductible	64% after deductible
Outpatient Substance Abuse Services (20 visits per benefit period)	80% after deductible	64% after deductible

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.

¹Maximum family deductible. Member deductible is the same as single deductible. 3-month 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 subject to deductible.



**Dentist's Choice Health Care Alliance
SuperMed Plus 2000/4000
08/01/09**



Benefits	Network	Non-Network
Benefit Period	January 1 st through December 31 st	
Dependent Age Limit	24 th Birthday	
Lifetime Maximum	\$2,500,000	
Benefit Period Deductible – Non-embedded ¹	\$2,000 Single Contract \$4,000 Family Contract	
Coinsurance	80%	60%
Coinsurance Out-of-Pocket Maximum ² (Excluding Deductible) – Single/Family	\$2,000 Single Contract \$4,000 Family Contract	\$4,000 Single Contract \$8,000 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
Voluntary Second Surgical Opinion	80% after deductible	60% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	80% after deductible	60% after deductible
Preventative Services		
Routine Physical Exam	100%	60% after deductible
Well Child Care Services including Exam and Immunizations (To age nine, limited to a \$1,000 maximum per benefit period)	100%	60% after deductible
Well Child Care Laboratory Tests (To age nine)	100%	60% after deductible
Routine Colorectal Screening and Endoscopic Services (Over age 50)	100%	60% after deductible
Routine Mammogram (One per benefit period)	100%	60% after deductible
Routine Pap Test (One per benefit period)	100%	60% after deductible
Routine Prostate Specific Antigen (PSA)	100%	60% after deductible
Routine Vision Exam (One per benefit period)	80% after deductible	60% after deductible
Routine Chest X-Ray, EKG, Complete Metabolic Panel, Urine Analysis, Complete Blood Count (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
Emergency use of an Emergency Room	80% after deductible	
Non-Emergency use of an Emergency Room	80% after deductible	60% after deductible

Benefits	Network	Non-Network
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 ³	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 (30 days per benefit period; Substance Abuse limited to 1 admit per benefit period; 3 admissions per lifetime)	80% after deductible	60% after deductible
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	80% after deductible	60% 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.

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 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



**Dentist's Choice Health Care Alliance
SuperMed Classic 250/500
08/01/09**



Benefits	Network Facility / Any Professional Provider	Non-Network Facility
Benefit Period	January 1 st through December 31 st	
Dependent Age Limit	24 th Birthday	
Lifetime Maximum	\$2,500,000	
Benefit Period Deductible – Single/Family ¹	\$250 / \$500	
Coinsurance	80%	64%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	\$2,000 / \$4,000	\$4,000 / \$8,000
Physician/Office Services		
Office Visit (Illness/Injury) ²	\$20 copay, then 100%	
Urgent Care Office Visit ²	\$20 copay, then 100%	
Voluntary Second Surgical Opinion	80% after deductible	
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	80% after deductible	
Preventative Services		
Routine Physical Exam (Ages nine and over) ²	\$20 copay, then 100%	
Well Child Care Services including Exam and Immunizations (To age nine, limited to a \$1,000 maximum per benefit period) ²	\$20 copay, then 100%	
Well Child Care Laboratory Tests (To age nine)	100%	80% after deductible
Routine Colorectal Screening and Endoscopic Services (Over age 50)	100%	80% after deductible
Routine Mammogram (One per benefit period)	100%	80% after deductible
Routine Pap Test (One per benefit period)	100%	80% after deductible
Routine Prostate Specific Antigen (PSA)	100%	80% after deductible
Routine Vision Exam (One per benefit period)	\$20 copay, then 100%	
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (Ages nine and over, one each per benefit period)	100%	80% after deductible
Outpatient Services		
Surgical Services	80% after deductible	64% after deductible
Diagnostic Services	80% after deductible	64% after deductible
Physical/Chiropractic Therapy - Facility and Professional (10 visits then subject to Medical Review)	80% after deductible	64% after deductible
Speech Therapy – Facility and Professional (10 visits then subject to Medical Review)	80% after deductible	
Emergency use of an Emergency Room ³	\$100 copay, then 80%	
Non-Emergency use of an Emergency Room ³	\$100 copay, then 80%	\$100 copay, then 64%

Benefits	Network Facility / Any Professional Provider	Non-Network Facility
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	80% after deductible	64% after deductible
Allergy Treatments	80% 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	
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (22 days per benefit period)	80% after deductible	64% after deductible
Outpatient Mental Health (20 visits per benefit period)	80% after deductible	64% after deductible
Outpatient Substance Abuse Services (20 visits per benefit period)	80% after deductible	64% after deductible

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

Deductible expenses incurred for services by a network provider will also apply to the non-network deductible. Deductible expenses incurred for services by a non-network provider will also apply to the network deductible.

Coinsurance expenses incurred for services by a network provider will also apply to the non-network coinsurance out-of-pocket limits. Coinsurance expenses incurred for services by a non-network provider will also apply to the network 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. 3-month 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 subject to deductible.



**Dentist's Choice Health Care Alliance
SuperMed Classic 500/1000
08/01/09**



Benefits	Network Facility / Any Professional Provider	Non-Network Facility
Benefit Period	January 1 st through December 31 st	
Dependent Age Limit	24 th Birthday	
Lifetime Maximum	\$2,500,000	
Benefit Period Deductible – Single/Family ¹	\$500 / \$1,000	
Coinsurance	80%	64%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	\$2,000 / \$4,000	\$4,000 / \$8,000
Physician/Office Services		
Office Visit (Illness/Injury) ²	\$25 copay, then 100%	
Urgent Care Office Visit ²	\$25 copay, then 100%	
Voluntary Second Surgical Opinion	80% after deductible	
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	80% after deductible	
Preventative Services		
Routine Physical Exam (Ages nine and over) ²	\$25 copay, then 100%	
Well Child Care Services including Exam and Immunizations (To age nine, limited to a \$1,000 maximum per benefit period) ²	\$25 copay, then 100%	
Well Child Care Laboratory Tests (To age nine)	100%	80% after deductible
Routine Colorectal Screening and Endoscopic Services (Over age 50)	100%	80% after deductible
Routine Mammogram (One per benefit period)	100%	80% after deductible
Routine Pap Test (One per benefit period)	100%	80% after deductible
Routine Prostate Specific Antigen (PSA)	100%	80% after deductible
Routine Vision Exam (one per benefit period)	\$25 copay, then 100%	
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (Ages nine and over, one each per benefit period)	100%	80% after deductible
Outpatient Services		
Surgical Services	80% after deductible	64% after deductible
Diagnostic Services	80% after deductible	64% after deductible
Physical/Chiropractic Therapy - Facility and Professional (10 visits then subject to Medical Review)	80% after deductible	64% after deductible
Speech Therapy – Facility and Professional (10 visits then subject to Medical Review)	80% after deductible	64% after deductible
Emergency use of an Emergency Room ³	\$100 copay, then 80%	
Non-Emergency use of an Emergency Room ³	\$100 copay, then 80%	\$100 copay then 64%

Benefits	Network Facility / Any Professional Provider	Non-Network Facility
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	80% after deductible	64% after deductible
Allergy Treatments	80% 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	
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (22 days per benefit period)	80% after deductible	64% after deductible
Outpatient Mental Health (20 visits per benefit period)	80% after deductible	64% after deductible
Outpatient Substance Abuse Services (20 visits per benefit period)	80% after deductible	64% after deductible

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

Deductible expenses incurred for services by a network provider will also apply to the non-network deductible. Deductible expenses incurred for services by a non-network provider will also apply to the network deductible.

Coinsurance expenses incurred for services by a non-network provider will also apply to the 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.

¹Maximum family deductible. Member deductible is the same as single deductible. 3-month 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 subject to deductible.



**Dentist's Choice Health Care Alliance
SuperMed Classic Gold 250/500
08/01/09**



Benefits	Network Facility	Non-Network Facility / Any Professional Provider
Benefit Period	January 1 st through December 31 st	
Dependent Age Limit	24 th Birthday	
Lifetime Maximum	\$2,500,000	
Benefit Period Deductible – Single/Family ¹	\$250 / \$500	
Coinsurance	90%	80%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	\$2,000 / \$4,000	
Physician/Office Services		
Office Visit (Illness/Injury) ²	\$20 copay, then 100%	
Urgent Care Office Visit ²	\$20 copay, then 100%	
Voluntary Second Surgical Opinion	80% after deductible	
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	80% after deductible	
Preventative Services		
Routine Physical Exam (Ages nine and over) ²	\$20 copay, then 100%	
Well Child Care Services including Exam and Immunizations (To age nine, limited to a \$1,000 maximum per benefit period) ²	\$20 copay, then 100%	
Well Child Care Laboratory Tests (To age nine)	100%	80% after deductible
Routine Colorectal Screening and Endoscopic Services (Over age 50)	100%	80% after deductible
Routine Mammogram (One per benefit period)	100%	80% after deductible
Routine Pap Test (One per benefit period)	100%	80% after deductible
Routine Prostate Specific Antigen (PSA)	100%	80% after deductible
Routine Vision Exam (One per benefit period)	\$20 copay, then 100%	
Routine EKG, chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (Ages nine and over, one each per benefit period)	100%	80% after deductible
Outpatient Services		
Surgical Services	90% after deductible	80% after deductible
Diagnostic Services	90% after deductible	80% after deductible
Physical/Chiropractic Therapy - Facility and Professional (10 visits then subject to Medical Review)	90% after deductible	80% after deductible
Speech Therapy – Facility and Professional (10 visits then subject to Medical Review)	90% after deductible	80% after deductible
Emergency use of an Emergency Room ³	\$100 copay then 90%	
Non-Emergency use of an Emergency Room ³	\$100 copay then 90%	\$100 copay then 80%

Benefits	Network Facility	Non-Network Facility / Any Professional Provider
Inpatient Facility		
Semi-Private Room and Board	90% after deductible	80% after deductible
Maternity	90% after deductible	80% after deductible
Skilled Nursing Facility	90% after deductible	80% after deductible
Additional Services		
Allergy Testing	90% after deductible	80% after deductible
Allergy Treatments	80% after deductible	
Ambulance	90% after deductible	80% after deductible
Durable Medical Equipment	90% after deductible	80% after deductible
Home Healthcare	90% after deductible	80% after deductible
Hospice	90% after deductible	80% after deductible
Organ Transplants	90% after deductible	80% after deductible
Private Duty Nursing (\$5,000 maximum per benefit period)	80% after deductible	
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (22 days per benefit period)	90% after deductible	80% after deductible
Outpatient Mental Health (20 visits per benefit period)	90% after deductible	80% after deductible
Outpatient Substance Abuse Services (20 visits per benefit period)	90% after deductible	80% after deductible

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

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. 3-month 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 subject to deductible.



**Dentist's Choice Health Care Alliance
SuperMed Classic Gold 500/1000
08/01/09**



Benefits	Network Facility	Non-Network Facility / Any Professional Provider
Benefit Period	January 1 st through December 31 st	
Dependent Age Limit	24 th Birthday	
Lifetime Maximum	\$2,500,000	
Benefit Period Deductible – Single/Family ¹	\$500 / \$1,000	
Coinsurance	90%	80%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	\$2,000 / \$4,000	
Physician/Office Services		
Office Visit (Illness/Injury) ²	\$25 copay, then 100%	
Urgent Care Office Visit ²	\$25 copay, then 100%	
Voluntary Second Surgical Opinion	80% after deductible	
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	80% after deductible	
Preventative Services		
Routine Physical Exam (Ages nine and over) ²	\$25 copay, then 100%	
Well Child Care Services including Exam and Immunizations (To age nine, limited to a \$1,000 maximum per benefit period) ²	\$25 copay, then 100%	
Well Child Care Laboratory Tests (To age nine)	100%	80% after deductible
Routine Colorectal Screening and Endoscopic Services (Over age 50)	100%	80% after deductible
Routine Mammogram (One per benefit period)	100%	80% after deductible
Routine Pap Test (One per benefit period)	100%	80% after deductible
Routine Prostate Specific Antigen (PSA)	100%	80% after deductible
Routine Vision Exam (One per benefit period)	\$25 copay, then 100%	
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (Ages nine and over, one each per benefit period)	100%	80% after deductible
Outpatient Services		
Surgical Services	90% after deductible	80% after deductible
Diagnostic Services	90% after deductible	80% after deductible
Physical/Chiropractic Therapy - Facility and Professional (10 visits then subject to Medical Review)	90% after deductible	80% after deductible
Speech Therapy – Facility and Professional (10 visits then subject to Medical Review)	90% after deductible	80% after deductible
Emergency use of an Emergency Room ³	\$100 copay, then 90%	
Non-Emergency use of an Emergency Room ³	\$100 copay, then 90%	\$100 copay, then 80%

Benefits	Network Facility	Non-Network Facility / Any Professional Provider
Inpatient Facility		
Semi-Private Room and Board	90% after deductible	80% after deductible
Maternity	90% after deductible	80% after deductible
Skilled Nursing Facility	90% after deductible	80% after deductible
Additional Services		
Allergy Testing	90% after deductible	80% after deductible
Allergy Treatments	80% after deductible	
Ambulance	90% after deductible	80% after deductible
Durable Medical Equipment	90% after deductible	80% after deductible
Home Healthcare	90% after deductible	80% after deductible
Hospice	90% after deductible	80% after deductible
Organ Transplants	90% after deductible	80% after deductible
Private Duty Nursing (\$5,000 maximum per benefit period)	80% after deductible	
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (22 days per benefit period)	90% after deductible	80% after deductible
Outpatient Mental Health (20 visits per benefit period)	90% after deductible	80% after deductible
Outpatient Substance Abuse Services (20 visits per benefit period)	90% after deductible	80% 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 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.

¹Maximum family deductible. Member deductible is the same as single deductible. 3-month 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 subject to deductible.