SUPERMED ONE Value 500

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependent, 23 Student; Removal upon End of Month	
Lifetime Maximum	$2,000,000	
Benefit Period Deductible – Single/Family	$500/$1,000	$1,500/$3,000
Coinsurance	70%	50%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	$3,500/$7,000	$7,500/$15,000
Physician/Office Services		
Office Visit (Illness/Injury)	70% after deductible	50% after deductible
Urgent Care Office Visit	70% after deductible	50% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	70% after deductible	50% after deductible[1]
Preventative Services		
Routine Physical Exam	NOT COVERED	
Well Child Care services to age nine. Well child Exams & Well Child Immunizations are limited to $500 per child to age 1; thereafter, $150 per child per birth year to age 9)	70% after deductible	50% after deductible
Routine Mammogram (One per benefit period)	70% after deductible	50% after deductible
Routine Pap Test (One per benefit period)	70% after deductible	50% after deductible
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period)	NOT COVERED	
Outpatient Services		
Allergy Testing and Treatments	70% after deductible	50% after deductible[1]
Diagnostic Services	70% after deductible	50% after deductible
Surgery	70% after deductible	50% after deductible
Physical Therapy (Institutional & Professional – 10 visits per benefit period)	70% after deductible	50% after deductible
Occupational Therapy (Institutional & Professional – 10 visits per benefit period)	70% after deductible	50% after deductible
Speech Therapy (Institutional & Professional – 10 visits per benefit period)	70% after deductible	50% after deductible
Chiropractic Therapy (Professional Only – 6 visits per benefit period)	70% after deductible	50% after deductible
Cardiac Rehabilitation	NOT COVERED	
Emergency use of an Emergency Room	70% after deductible	
Non-Emergency use of an Emergency Room	NOT COVERED	
Inpatient Facility		
Semi-Private Room and Board	70% after deductible	50% after deductible
Skilled Nursing Facility ($10,000 maximum per benefit period)	70% after deductible	50% after deductible
Additional Services		
Ambulance ($300 Maximum per benefit period)	70% after deductible	70% after deductible
Durable Medical Equipment	50% after deductible	50% after deductible
Home Healthcare (60 visits per benefit period)	70% after deductible	50% after deductible[1]
Hospice	70% after deductible	50% after deductible[1]
Organ and Tissue Transplants[2]	70% after deductible	50% after deductible
Value Vision	Discount[3]	None

Benefits listed are effective JANUARY 1, 2006

Benefits	Network	Non-Network
Mental Health and Substance Abuse		
Inpatient Mental Health/Substance Abuse Services: (10 days per benefit period; Inpatient and Outpatient Substance Abuse limited to $550 per benefit period)	70% after deductible	50% after deductible[1]
Outpatient Mental Health/Substance Abuse Visits (10 visits per benefit period; Inpatient and Outpatient Substance Abuse limited to $550 per benefit period)	50% after deductible[1]	50% after deductible[1]
Prescription Drug – Oral Contraceptives Included		
Benefit period maximum	$500	
Retail – 30 Day Supply	$15 copay – Generic drugs only[4]	
Home Delivery	NOT COVERED	

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

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

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] Coinsurance does not apply to out-of-pocket maximum. These services will not be covered at 100% once out of pocket maximum is met.

[2] 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 a Non Designated Organ Transplant Network provider. This penalty may be waived by the Case Manager if the proper pre-determination procedures are followed.

[3] A separate Value Vision discount program highlight sheet is available. If SuperMed Vision is purchased, Value Vision will be removed from the base benefit.

[4] The prescription drug benefit does not cover brand-name prescriptions under any circumstance. This applies even if a brand name drug is medically necessary and a generic substitute is not available. This also applies even when your doctor writes "dispense as written" on your prescription.