

**SMPlus 500-1000
SuperMed® Script
Benefit Summary**



Benefit/Feature	In Network Providers SMP PPO Network www.medmutual.com	Out-of-Network Providers
Benefit Period	January 1 st through December 31 st	
Dependent Age	26, Removal end of month after Birthday	
Benefit Period Deductible – Single/Family ¹	\$500 / \$1,000	
Coinsurance	80%	64%
Out-of-Pocket Maximum (Includes deductible, coinsurance and copays) – Single/Family	\$3,000 / \$6,000	\$5,500 / \$11,000
Physician/Office Services		
Office Visit (Illness/Injury) / Specialty ²	\$25 copay / \$35 copay then 100%	64% after deductible
Urgent Care Office Visit ²	\$25 copay, then 100%	64% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	100%	64% after deductible
Preventative Services		
Preventive Services, in accordance with state and federal law³		
Routine Physical Exam (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
Women Preventive Benefits (unless otherwise specified under the preventive benefits)	100%	64% after deductible
Mammogram and Pap Test (all ages 1 per benefit period)	100%	80% after deductible
Routine Vision Exam (21 and over, one per benefit period)	\$25 copay, then 100%	80% after deductible
Routine Prostate Specific Antigen (PSA) (all ages)	100%	80% after deductible
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (all ages, 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 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
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		

Prescription Drug Program		
SuperMed Script⁵ 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 Day Supply
Formulary Copayment	\$30	30 Day Supply
Non-Formulary Copayment	\$50	30 Day Supply
4 th Tier Specialty Drug	25% or \$200 whichever is less	Limited to 30 Day Supply
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 Day Supply
Formulary Copayment	\$90	30 Day Supply
Non-Formulary Copayment	\$150	30 Day Supply
SuperMed Script Home Delivery Program with Oral Contraceptive Coverage, your copay is		
Generic Copayment	\$45	90 Day Supply
Formulary Copayment	\$90	90 Day Supply
Non-Formulary Copayment	\$150	90 Day Supply
4th Tier Specialty Drug	25% or \$200 whichever is less	Limited to 30 Day Supply

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 non-network provider will also apply to the network coinsurance out-of-pocket limits.

The Coinsurance percentage will be the same for Non-Contracting Providers as Non-PPO Network Providers but you may still be subject to balance billing and/or Excess Charges. Payments to Contracting Non-PPO Network Providers are based on Allowed Amount. Payments to Non-Contracting Providers are based on the Non-Contracting Amount.

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

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.

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.

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.

¹Maximum family deductible. Member deductible is the same as single deductible.

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

³Preventive 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.

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

⁵SuperMed 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 Deliver Incentive: When a member chooses to fill a prescription on a fourth time at a retail pharmacy within 180 days, the member will pay three times the normal retail copayment.

