MMI: 001800247000000000
Effective Date: 010118
Performance Guarantee: Y

Group Benefit Summary Report

12/28/2023 12:29 PM

Group

Group Number	Group Name	Section
418649	Madison Local Schools	002,007

Signature

I have reviewed the entire Group Benefit Summary Report and it is approved with no changes:

_____
Print Name

_____
Signature

_____
Title

_____
Date

Grandfathered Status

I confirm this plan is Grandfathered as defined by the Affordable Care Act (45 CFR 147.140 Preservation of right to maintain existing coverage)

Signature _____

Or, initial if not applicable_____

Medical

Subcategory	Variable	Network	Non-Network
General Information			
Product		SuperMed Plus CMM	
Plan Name		Plan 2	
Dependent Age		(effective 11/1/20) No Age Restriction - Certification Required; Dependents between the ages of 26 and 99 are covered while they are still in school. The group will monitor the eligibility	

Subcategory	Variable	Network	Non-Network
		requirements and certification	
Student Age		No Age Restriction - Certification Required; Dependents between the ages of 26 and 99 are covered while they are still in school. The group will monitor the eligibility requirements and certification	
Older Age Child		26	
Dependent Removal		End of Month	
Pre-existing Condition Waiting Period		Does Not Apply	
Lifetime Maximum		Unlimited	
Overall Benefit Period Maximum		Unlimited	
Network and Non-Network Benefit Maximums		Integrated	
Claims Filing Limit		12 months	
Case Management		Yes	
Precertification		Yes - Provider Driven	Yes - Provider Driven
Blood Pint Deductible		0 pints	
3 Month Deductible Carryover Credit		Yes	
Route Code		4349	
How Claims are Paid			
COB Processing - contact Benefit Services to confirm coverage		Pay and Pursue (Indicator - 0 0)	
Other Carrier Liability (OCL)		10008 - pay to fill	
Non Contracting Providers		Same as Non-Network	
Benefit Period		January 1st through December 31st	
Type of SuperMed Processing		Flat	
Coinsurance		90%	70%
Benefit Period Deductible - Single		$350	$700
Benefit Period Deductible - Family		$700	$1,400
Type of Deductible Accumulation		Integrated - Deductible incurred for a non-network provider will also apply to the network deductible limits. Deductible incurred for a network provider will also apply to the non-network limits.	
Type of Deductible Processing		Embedded Deductible	
Deductible - Common Accident		Yes	
Coinsurance Out-of-Pocket Limits (Excludes Deductible) - Single		$250	$500
Coinsurance Out-of-		$500	$1,000

Subcategory	Variable	Network	Non-Network
Pocket Limits (Excludes Deductible) - Family			
Type of Coinsurance Out-of-Pocket Accumulation		Integrated - Coinsurance incurred for a non-network provider will also apply to the network coinsurance limits. Coinsurance incurred for a network provider will also apply to the non-network limits.	
Type of Coinsurance Out-of-Pocket Processing		Embedded Coinsurance	
Maximum Out-of-Pocket Limits - Single (the sum of any applicable deductible, coinsurance and copays)	(includes medical and drug services)	$750	$1,500
Maximum Out-of-Pocket Limits - Family (the sum of any applicable deductible, coinsurance and copays)	(includes medical and drug services)	$1,500	$3,000
Type of Copay Processing		MOOP Accumulation Copay Processing(Medical/Drug)-Copays accumulate to the Maximum Out-of-Pocket (MOOP) Limits and they stop being taken once the MOOPs are met.	
Emergency Room			
Emergency - Medical/Accident - Emergency Room		$150 copay, then 90% (copay is waived if admitted)	
Emergency - Medical/Accident - Related Services		90%	
Emergency - Medical/Accident - Physician		90%	
Non-Emergency - Emergency Room		90% after deductible	70% after deductible
Non-Emergency - Related Services		90% after deductible	70% after deductible
Non-Emergency - Physician		90% after deductible	70% after deductible
Inpatient Services			
Anesthesia		90% after deductible	70% after deductible
Consultations		90% after deductible	70% after deductible
Newborn Care		90% after deductible	70% after deductible
Institutional Services		90% after deductible	70% after deductible
Maternity		90% after deductible	70% after deductible
Physical Medicine and Rehabilitation		90% after deductible	70% after deductible
Professional Services		90% after deductible	70% after deductible
Skilled Nursing Facility (SNF)		90% after deductible	70% after deductible

Subcategory	Variable	Network	Non-Network
Mental Health, Alcohol and Drug Abuse			
Inpatient Alcoholism Services		Benefits paid based on corresponding medical benefits	
Inpatient Drug Abuse Services		Benefits paid based on corresponding medical benefits	
Inpatient Mental Health Services		Benefits paid based on corresponding medical benefits	
Lifetime Maximum(s)		Benefits paid based on corresponding medical benefits	
Outpatient Alcoholism Services		Benefits paid based on corresponding medical benefits	
Outpatient Drug Abuse Services		Benefits paid based on corresponding medical benefits	
Outpatient Mental Health Services		Benefits paid based on corresponding medical benefits	
Parity - Mental Health/Residential		Yes	
Health Care Reform - Mental Health/Substance Abuse Benefits		100%	Benefits paid based on services rendered
Office Visits(illness/injury)			
Medically Necessary Office Visits/Consultations/ Telehealth - PCP		$25 copay, then 100%	70% after deductible
On Demand Virtual Telehealth		$25 copay, then 100%	70% after deductible
Medically Necessary Office Visits/Consultations/ Telehealth - Specialist		$25 copay, then 100%	70% after deductible
Urgent Care Provider Office Visits		90% after deductible	70% after deductible
Outpatient Services			
Allergy Testing		90% after deductible	70% after deductible
Allergy Treatment		90% after deductible	70% after deductible
Diagnostic Imaging		90% after deductible	70% after deductible
Diagnostic Lab		90% after deductible	70% after deductible
Diagnostic Medical Tests		90% after deductible	70% after deductible
Diagnostic X-ray		90% after deductible	70% after deductible
Education and Training	(excludes Diabetic Education and Training)	Not Covered, unless the service is covered under Health Care Reform Preventive Benefits	Not Covered
Education and Training/Diabetic		90% after deductible, unless the service is covered under Health Care Reform Preventive Benefits	70% after deductible
Home Health Care		90% after deductible	70% after deductible
Immunizations	(All Immunizations)	$20 copay, then 100%, unless	70% after deductible

Subcategory	Variable	Network	Non-Network
		the service is covered under Health Care Reform Preventive Benefits	
Maternity	(Prenatal Visits are covered at no charge with in-network providers)	90% after deductible	70% after deductible
Surgical Services - Anesthesia		90% after deductible	70% after deductible
Surgical Services - Assistant Surgeon		90% after deductible	70% after deductible
Surgical Services - Surgery Professional		90% after deductible	70% after deductible
Surgical Services - Surgery Facility		90% after deductible	70% after deductible
Surgical Services - Diagnostic Endoscopic Services		90% after deductible	70% after deductible
Outpatient Therapy			
Cardiac Rehabilitation		90% after deductible	70% after deductible
Chemotherapy		90% after deductible	70% after deductible
Chiropractic	(25 visits per benefit period)	90% after deductible	70% after deductible
Dialysis Treatment		90% after deductible	70% after deductible
Hyperbaric Therapy		90% after deductible	70% after deductible
Occupational Therapy		90% after deductible	70% after deductible
Physical Therapy		90% after deductible	70% after deductible
Pulmonary Therapy		90% after deductible	70% after deductible
Radiation Therapy		90% after deductible	70% after deductible
Respiratory Therapy		90% after deductible	70% after deductible
Speech Therapy		Not Covered	Not Covered
Preventive Government Mandated Benefits			
Health Care Reform Preventive Benefits		100%	70% after deductible
Health Care Reform Preventive Benefits for Women		100%	70% after deductible
Preventive Exams and Immunizations			
Family Planning Exam	(age 21 and over)	100%	70% after deductible
Immunizations	(All Immunizations)	$20 copay, then 100%, unless the service is covered under Health Care Reform Preventive Benefits	70% after deductible
Physical Exam	(age 21 and over)	100%	70% after deductible
Preventive Tests			
Bone Density Tests		100%	70% after deductible
Endoscopic Services		100%	70% after deductible
Lab		100%	70% after deductible
Mammogram	(1 per benefit period)	100%	70% after deductible

Subcategory	Variable	Network	Non-Network
Medical Tests		100%	70% after deductible
Pap Test	(1 per benefit period)	100%	70% after deductible
X-rays		100%	70% after deductible
Well Child Care			
Covered up to the age of		21	
Maximum		Unlimited	
Exams		100%	70% after deductible
Family Planning Exams		100%	70% after deductible
Hearing Exams		100%	70% after deductible
Immunizations	(All Immunizations)	100%	70% after deductible
Labs		100%	70% after deductible
Vision Exams		100%	70% after deductible
Additional Services			
Abortions - Elective		Not Covered	Not Covered
Abortions - Therapeutic		90% after deductible	70% after deductible
Acupuncture		Not Covered	Not Covered
Ambulance		90% after deductible	70% after deductible
Approved Clinical Trial		Benefits paid based on services rendered	
Autism Spectrum Disorders (other than ABA)	Unlimited (all ages)	Benefits paid based on services rendered	
Applied Behavior Analysis(ABA)	Unlimited (all ages)	Benefits paid based on services rendered	
Blood, Blood Typing and Administration		90% after deductible	70% after deductible
Diabetes Disease Management (DM) Program	Materials covered under the DM program are not listed in certificate	Full Supplies and DME - no cost share	
Durable Medical Equipment	(Includes Lift Chair and Foot Orthotics)	90% after deductible	70% after deductible
Gender Affirming Surgery		Benefits paid based on services rendered	
Hospice		90% after deductible	70% after deductible
Medical Supplies	(includes Jobst Stockings and support/compression stockings)	90% after deductible	70% after deductible
Non-emergency care when traveling outside the United States		Not Covered	Not Covered
Oral Accident		90% after deductible	70% after deductible
Organ Transplant		90% after deductible	70% after deductible
Private Duty Nursing		90% after deductible	70% after deductible
TMJ		Benefits paid based on services rendered	
Weight Loss Surgical Services (Bariatric Surgery)	(including any repairs, revisions or modifications of such surgery)	Benefits paid based on services rendered	

Drug

Subcategory	Variable	
General Information		
Product		Major Medical Drug - Realtime Processing - Next Gen
3 Month Deductible Carryover Credit		Yes
Formulary with Integrated Coverage Management Programs		There is no Coverage Management
Coverage Management with 90 day waiver member notification		N/A
Pharmacy Network		National Plus Maintenance
Specialty Drug Solution Pharmacy Network	(with Pre-Notes)	Applies
SaveonSP		Apply Public Entities SaveonSP Drug List
True Payment Processing(TPP)		Applies
Pricing Method		Pass Through
Insulin Method		Method 5
How Claims are Paid		
Benefit Period		January 1st through December 31st
HCR Preventive Benefits - Drug		100%
Contraceptive Coverage and HCR Preventive Benefits for Women - Drug		100%
Benefit Period Deductible - Single	(combined with medical)	$350
Benefit Period Deductible - Family	(combined with medical)	$700
Coinsurance Out-of-Pocket Limits (Excludes Deductible) - Single		N/A
Coinsurance Out-of-Pocket Limits (Excludes Deductible) - Family		N/A
Maximum Out-of-Pocket Limits - Single (the sum of any applicable deductible, coinsurance and copays)	(includes medical and drug services)	$750
Maximum Out-of-Pocket Limits - Family (the sum of any applicable deductible, coinsurance and copays)	(includes medical and drug services)	$1,500
Major Medical Drug Coverage	Covers up to a 30 day supply (specialty drugs); 90 day supply (all other drugs)	90% after deductible
Home Delivery Incentive		N/A
Specialty Drug		
Specialty Drugs	(effective 07/01/2020)Covers up to a 30 day supply. Certain specialty drugs are considered non-essential health benefits and therefore do not apply to the out-of-pocket maximum. They will also be subject to higher cost-share.	Applicable drug tier copay applies or the max of any available manufacturer-funded copay assistance.
Commonly Covered or Excluded Drugs and Programs		
Asthmatic Supplies		Not Covered
Compound Drug Management		Participates

Subcategory	Variable	
Diabetic Supplies (over-the-counter)	(includes over-the-counter items, except for glucose monitors and meters)	Covered
Fertility Drugs		Covered
Growth Hormones		Covered
Immunizations/Vaccines		Covered
Injectables		Covered
Sexual Dysfunction Drugs		Covered
Smoking Cessation Drugs (non-OTC)		Covered
Smoking Cessation Drugs (over-the-counter)		Not Covered, unless the service is covered under HCR Preventive Benefits - Drugs
Weight Loss Drugs		Not Covered

Benefits will be administered by Medical Mutual of Ohio. 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. Only 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.