

Group Benefit Summary Report

12/21/2023 12:33 PM

MMI: 00710217800000000 Effective Date: 010124 Performance Guarantee: Y

Group

Group Number	Group Name	Section
418649	Madison Local Schools	018,019

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	
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Or, initial if not applicable_____

Medical

Subcategory	Variable	Network	Non-Network
General Information			
Product		SuperMed Plus CMM - HSA	
Plan Name		Plan 4	
Dependent 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	

Subcategory	Variable	Network	Non-Network	
		certification	· · ·	
Student Age		No Age Restriction - Cer	No Age Restriction - Certification Required; Dependents	
		between the ages of 26	and 99 are covered while they are still in	
		school. The group will m	onitor the eligibility requirements and	
		certification		
Older Age Child		26		
Dependent Removal		End of Month		
Pre-existing Condition		Does Not Apply		
Waiting Period				
Lifetime Maximum		Unlimited		
Overall Benefit Period		Unlimited		
Maximum				
Network and Non-		Integrated		
Network Benefit				
Maximums				
Claims Filing Limit		12 months		
Case Management		Yes		
Precertification		Yes - Provider Driven	Yes - Provider Driven	
Blood Pint Deductible		0 pints		
3 Month Deductible		No		
Carryover Credit				
Route Code		4349		
How Claims are Paid	1			
COB Processing - contact		Pay and Pursue (Indicate	or - 0 0)	
Benefit Services to				
confirm coverage				
Other Carrier Liability		10008 - pay to fill	10008 - pay to fill	
(OCL)				
Non Contracting		Same as Non-Network		
Providers				
Benefit Period		January 1st through Dec	ember 31st	
Type of SuperMed		Flat		
Processing				
Coinsurance		100%	70%	
Benefit Period		\$3,200	\$3,500	
Deductible - Single				
Benefit Period		\$5,600	\$7,000	
Deductible - Family				
Type of Deductible		-	Integrated - Deductible incurred for a non-network provider will	
Accumulation		also apply to the network deductible limits. Deductible incurred		
		for a network provider will also apply to the non-network limits.		
Type of Deductible		Embedded Deductible		
Processing				
Deductible - Common		Yes		
Accident			42.000	
Coinsurance Out-of-		\$0	\$2,000	
Pocket Limits (Excludes				
Deductible) - Single			<u> </u>	
Coinsurance Out-of-		\$0	\$4,000	

Pocket Limits [Excludes Deductible) - FamilyN/AType of Coinsurance Out-of-Pocket AccumulationN/AType of Coinsurance Out-of-Pocket Type of CoinsuranceEmbedded Coinsurance Out-of-Pocket Type of CoinsuranceOut-of-Pocket Maximum Out-of-Pocket (includes medical and drug services)\$3,200\$5,500Maximum Out-of-Pocket deductible, coinsurance and copary)(includes medical and drug services)\$3,200Maximum Out-of-Pocket deductible, coinsurance and copary)(includes medical and drug services)\$5,600\$11,000Maximum Out-of-Pocket dran applicable deductible, coinsurance and copary)Does Not Apply (there are no copary)\$1,000Type of Copay Type of Copay ProcessingDoes Not Apply (there are no copary)\$1,000Type of Copay Processing100% after deductible\$1,000Temegency - Medical/Accident - Emergency - Medical/Accident - Emergency - Non-Emergency - Physician100% after deductible70% after deductibleNon-Emergency - Physician100% after deductible70% after deductible70% after deductibleNon-Emergency - Physician100% after deductible70% after deductibleNon-Emergency - Physician <th>Subcategory</th> <th>Variable</th> <th>Network</th> <th>Non-Network</th>	Subcategory	Variable	Network	Non-Network
Type of Coinsurance N/A Out-of-Pocket Accumulation Type of Coinsurance Embedded Coinsurance Out-of-Pocket Processing Embedded Coinsurance Maximum Out-of-Pocket (includes medical and drug services) \$3,200 \$5,500 of any applicable deductible, coinsurance and copays) (includes medical and drug services) \$5,600 \$11,000 Maximum Out-of-Pocket (includes medical and drug services) \$5,600 \$11,000 Type of Copay Does Not Apply (there are no copays) Processing Type of Copay Does Not Apply (there are no copays) Processing Emergency - mergency Abom 100% after deductible Intervention Medical/Accident - Emergency - Medical/Accident - Physician 100% after deductible 70% after deductible Non-Emergency - Medical/Accident - Physician 100% after deductible 70% after deductible Non-Emergency - Physician 100% after deductible 70% after deductible Non-Emergency - Physician 100% after deductible 70% after deductible Non-Emergency - Physician 100% after deductible 70% after deductible Instructions 100% after deductible 70% after deductible	Pocket Limits (Excludes			
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Skilled Nursing Facility (SNF) 100% after deductible 70% after deductible	Rehabilitation			
(SNF)	Professional Services		100% after deductible	70% after deductible
	Skilled Nursing Facility		100% after deductible	70% after deductible
Mental Health, Alcohol and Drug Abuse	(SNF)			
	Mental Health, Alcohol and	Drug Abuse		
Inpatient Alcoholism Benefits paid based on corresponding medical benefits	•		Benefits paid based on corresp	onding medical benefits
Services	Services			

	Benefits paid based on correspor	
		naing medical benefits
		5
	Benefits paid based on correspon	nding medical benefits
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	Benefits paid based on correspor	nding medical benefits
	Benefits paid based on correspor	nding medical benefits
		-
	Benefits paid based on correspor	nding medical benefits
		-
	Yes	
	100%	Benefits paid based on
		services rendered
	100% after deductible	70% after deductible
	100% after deductible	70% after deductible
	100% after deductible	70% after deductible
	100% after deductible	70% after deductible
	100% after deductible	70% after deductible
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	100% after deductible	70% after deductible
	100% after deductible	70% after deductible
excludes Diabetic	Not Covered, unless the	Not Covered
ducation and Training)	service is covered under Health	
0.	Care Reform Preventive	
	Benefits	
	100% after deductible, unless	70% after deductible
	the service is covered under	
	Health Care Reform Preventive	
	Benefits	
	100% after deductible	70% after deductible
All Immunizations)	100% after deductible, unless	70% after deductible
- /		_
	the service is covered under	
C	ducation and Training)	Benefits paid based on correspond Yes 100% 100% 100% after deductible 100% after deductible, unless

Subcategory	Variable	Network	Non-Network
		Benefits	
Maternity	(Prenatal Visits are covered at no charge with in-network providers)	100% after deductible	70% after deductible
Surgical Services -		100% after deductible	70% after deductible
Anesthesia			
Surgical Services -		100% after deductible	70% after deductible
Assistant Surgeon			
Surgical Services -		100% after deductible	70% after deductible
Surgery Professional			700/ 5
Surgical Services -		100% after deductible	70% after deductible
Surgery Facility			
Surgical Services -		100% after deductible	70% after deductible
Diagnostic Endoscopic			
Services Outpatient Therapy			
Cardiac Rehabilitation		100% after deductible	70% after deductible
Chemotherapy		100% after deductible	70% after deductible
Chiropractic	(25 visits per benefit	100% after deductible	70% after deductible
Chiropractic	period)		
Dialysis Treatment		100% after deductible	70% after deductible
Hyperbaric Therapy		100% after deductible	70% after deductible
Occupational Therapy		100% after deductible	70% after deductible
Physical Therapy		100% after deductible	70% after deductible
Pulmonary Therapy		100% after deductible	70% after deductible
Radiation Therapy		100% after deductible	70% after deductible
Respiratory Therapy		100% after deductible	70% after deductible
Speech Therapy		Not Covered	Not Covered
Preventive Government Ma	ndated Benefits		1
Health Care Reform		100%	70% after deductible
Preventive Benefits			
Health Care Reform		100%	70% after deductible
Preventive Benefits for			
Women	 		
Preventive Exams and Immu		1000/	70% often de ductible
Family Planning Exam	(age 21 and over)	100%	70% after deductible
Immunizations	(All Immunizations)	100% after deductible, 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
Medical Tests	(p= p=	100%	70% after deductible
Pap Test	(1 per benefit period)	100%	70% after deductible

X-rays 100% 70% after deductible Well Child Care 21 Covered up to the age of 21 Maximum Unlimited Exams 100% 70% after deductible Family Planning Exams 100% 70% after deductible Immunizations (All Immunizations) 100% 70% after deductible Labs 100% 70% after deductible 10% Additional Services 100% after deductible 70% after deductible Abortions - Elective Not Covered Not Covered Abortions - Energeutic 100% after deductible 70% after deductible Apploxed Clinical Trial Benefits paid based on services rendered Autism Spectrum Unlimited (all ages) Benefits paid based on services rendered Analysis/ABA) Inol% after deductible 70% after deductible Analysis/ABA) Inol% after deductible 70% after deductible Disorders (other than ABA) 100% after deductible 70% after deductible Appleid Behavior Malysis/ABA) Inol% after deductible 70% after deductible Disor Bisease Materials covered under the DM program are not listed in certif	Subcategory	Variable	Network	Non-Network
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Weight Loss Surgical Benefits paid based on services rendered Services (Bariatric Benefits paid based on services rendered	Private Duty Nursing		100% after deductible	70% after deductible
Services (Bariatric	ТМЈ		Benefits paid based on services	rendered
	Weight Loss Surgical		Benefits paid based on services	rendered
Surgery)	Services (Bariatric			
- ··	Surgery)			

Drug

Subcategory	Variable	
General Information		
Product		Major Medical Drug - Realtime
		Processing - Next Gen
3 Month Deductible Carryover Credit		Yes
Formulary with Integrated Coverage		There is no Coverage Management
Management Programs		
Coverage Management with 90 day		N/A
waiver member notification		
Pharmacy Network		National Plus Maintenance
Specialty Drug Solution Pharmacy	(with Pre-Notes)	Applies
Network		
SaveonSP		N/A
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		100%
Preventive Benefits for Women - Drug		
Benefit Period Deductible - Single	(combined with medical)	\$3,200
Benefit Period Deductible - Family	(combined with medical)	\$5,600
Coinsurance Out-of-Pocket Limits		N/A
(Excludes Deductible) - Single		
Coinsurance Out-of-Pocket Limits		N/A
(Excludes Deductible) - Family		
Maximum Out-of-Pocket Limits - Single	(includes medical and drug services)	\$3,200
(the sum of any applicable deductible,		
coinsurance and copays)		
Maximum Out-of-Pocket Limits -	(includes medical and drug services)	\$5,600
Family (the sum of any applicable		
deductible, coinsurance and copays)		
Major Medical Drug Coverage	Covers up to a 30 day supply	100% after deductible
	(specialty drugs); 90 day supply (all	
	other drugs)	
Home Delivery Incentive		N/A
Specialty Drug		-
Specialty Drugs		100% after deductible
Commonly Covered or Excluded Drugs and	Programs	
Asthmatic Supplies		Not Covered
Compound Drug Management		Participates
Diabetic Supplies (over-the-counter)	(except for glucose monitors and meters)	Covered
Fertility Drugs		Covered
Growth Hormones		Covered
Immunizations/Vaccines		Covered
Injectables		Covered

Subcategory	Variable	
Sexual Dysfunction Drugs		Covered
Smoking Cessation Drugs (non-OTC)		Covered
Smoking Cessation Drugs (over-the-		Not Covered, unless the service is
counter)		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.