Benefit Summary Report

10/17/2024 2:17 PM

Quote Name: 190735,010125,GoldPlan
Effective Date: 010125
Performance Guarantee: GoldPlan

Group

Group Number	Group Name	Section
190735	University of Toledo	001-004, 100-102, 200-202

Signature

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

Don Poulson
Print Name

Don Poulson
Signature

Associate Director Total Rewards
Title

10/21/2024
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 Don Poulson

Or, initial if not applicable_____

Medical

Subcategory	Variable	Tier 1	Tier 2	Tier 3
Tier Definition				
Tier 1	Panel Code 4Z (Institutional and Professional)	UToledo Health (UTMC & UTP) In-Network		
Tier 2	Network Code - 01 (Institutional and Professional)	SuperMed Providers		
Tier 3	Panel Code - None	All other providers either contracting or non-contracting		
General Information				
Product		SuperMed Plus - Multi-tier		
Plan Name		Gold Plan		
Dependent Age		26		
Dependent Removal		End of Calendar Year		
Network and Non-Network Benefit Maximums		Integrated		
Claims Filing Limit		12 months		
3 Month Deductible Carryover Credit		No		
How Claims are Paid				
Benefit Period		January 1st through December 31st		
Coinsurance		95%	85%	70%
Benefit Period Deductible - Single		$150	$300	$1,000
Benefit Period Deductible - Family		$300	$600	$2,000
Type of Deductible Accumulation		Non-standard - Deductibles for Tier 3 will apply to Tier 1 and 2. Deductible Tier 1 will also apply to Tier 2. Deductibles for Tier 2 will also apply to Tier 1.		
Type of Deductible Processing		Embedded Deductible		
Coinsurance Out-of-Pocket Limits (Excludes Deductible) - Single		$1,100	$2,200	$3,000
Coinsurance Out-of-Pocket Limits (Excludes Deductible) - Family		$2,200	$4,400	$6,000
Type of Coinsurance Out-of-Pocket Accumulation		Non-standard - Coinsurance for Tier 3 will apply to Tier 1 and 2. Coinsurance Tier 1 will also apply to Tier 2. Coinsurance for Tier 2 will also apply to Tier 1.		
Type of Coinsurance Out-of-Pocket Processing		Embedded Coinsurance		
Type of Copay Processing		COOP Accumulation Copay Processing(Medical only)-Copays accumulate to the Coinsurance Out-of-Pocket (COOP) Limits and they stop being taken once the COOPs are met, unless otherwise noted.		

Subcategory	Variable	Tier 1	Tier 2	Tier 3
Emergency Room				
Emergency - Medical/Accident - Emergency Room		$200 copay, then 100% (copay is waived if admitted)		
Emergency - Medical/Accident - Related Services		95% after deductible	85% after deductible	85% after deductible
Emergency - Medical/Accident - Physician		95% after deductible	85% after deductible	85% after deductible
Non-Emergency - Emergency Room		$200 copay, then 100% (copay is waived if admitted)	$200 copay, then 100% (copay is waived if admitted)	$200 copay, then 100% (copay is waived if admitted)
Non-Emergency - Related Services		95% after deductible	85% after deductible	85% after deductible
Non-Emergency - Physician		95% after deductible	85% after deductible	85% after deductible
Inpatient Services				
Anesthesia		95% after deductible	85% after deductible	70% after deductible
Consultations		95% after deductible	85% after deductible	70% after deductible
Newborn Care		95% after deductible	85% after deductible	70% after deductible
Institutional Services	(copay applies to all services except Organ Transplant, Maternity, Newborn Care, Skilled Nursing, Physical Medicine and Rehab)	95% after deductible	$100 copay per admission, then benefit period deductible, then 85%	$250 copay per admission, then benefit period deductible, then 70%
Maternity	(See Benefit Note for Maternity at UTMC)(Inpatient Facility Services are Not Applicable at UTMC. The group covers Professional and Outpatient facility services (if applicable)	95% after deductible	85% after deductible	70% after deductible
Physical Medicine and Rehabilitation	(limited to 60 days per benefit period when rendered in a Freestanding Rehabilitation Hospital)	95% after deductible	85% after deductible	70% after deductible
Professional Services		95% after deductible	85% after deductible	70% after deductible
Skilled Nursing Facility (SNF)	(120 days per benefit period)	95% after deductible	85% after deductible	70% after deductible

Subcategory	Variable	Tier 1	Tier 2	Tier 3
Mental Health and Substance Use Disorders				
Inpatient Substance Use Disorder Services - Alcohol		Benefits paid based on corresponding medical benefits		
Inpatient Substance Use Disorder Services - Drug		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 Substance Use Disorder Services - Alcohol		Benefits paid based on corresponding medical benefits		
Outpatient Substance Use Disorder Services - Drug		Benefits paid based on corresponding medical benefits		
Outpatient Mental Health Services		Benefits paid based on corresponding medical benefits		
Office Visits(illness/injury)				
Medically Necessary Office Visits/Consultations/ Telehealth - PCP		$15 copay, then 100%	$25 copay, then 100%	70% after deductible
On Demand Virtual Telehealth		N/A	$25 copay, then 100%	70% after deductible
Medically Necessary Office Visits/Consultations/ Telehealth - Specialist		$30 copay, then 100%	$40 copay, then 100%	70% after deductible
Urgent Care Provider Office Visits		N/A	$50 copay, then 100%	$50 copay, then 100%
Outpatient Services				
Allergy Testing		100%	100%	70% after deductible
Allergy Treatment		100%	100%	70% after deductible
Diagnostic Imaging		95% after deductible	85% after deductible	70% after deductible
Diagnostic Lab		95% after deductible	85% after deductible	70% after deductible
Diagnostic Medical Tests		95% after deductible	85% after deductible	70% after deductible
Diagnostic X-ray		95% after deductible	85% after deductible	70% after deductible
Education and Training	(excludes Education and Training for people with Diabetes)	Not Covered, unless the service is covered under Health Care Reform Preventive Benefits	Not Covered, unless the service is covered under Health Care Reform Preventive Benefits	Not Covered, unless the service is covered under Health Care Reform Preventive Benefits
Education and Training for People with Diabetes		95% after deductible, unless the service is covered under Health Care Reform Preventive Benefits	85% after deductible, unless the service is covered under Health Care Reform Preventive Benefits	70% after deductible

Subcategory	Variable	Tier 1	Tier 2	Tier 3
Home Health Care		N/A	85% after deductible	70% after deductible
Immunizations	(All Immunizations)	100%	100%	70% after deductible
Maternity	(Prenatal Visits are covered at no charge with in-network providers)(See Benefit Note for Maternity at UTMC)(Inpatient Facility Services are Not Applicable at UTMC. The group covers Professional and Outpatient facility services (if applicable)	100%	100%	70% after deductible
Surgical Services - Anesthesia	(except for removal of all extractions of teeth, which are not covered for all places of service)(except for penile implants which are not covered for all places of service)	95% after deductible	85% after deductible	70% after deductible
Surgical Services - Assistant Surgeon	(except for removal of all extractions of teeth, which are not covered for all places of service)(except for penile implants which are not covered for all places of service)	95% after deductible	85% after deductible	70% after deductible
Surgical Services - Surgery Professional	(except for removal of all extractions of teeth, which are not covered for all places of service)(except for penile implants which are not covered for all places of service)	95% after deductible	85% after deductible	70% after deductible

Subcategory	Variable	Tier 1	Tier 2	Tier 3
Surgical Services - Surgery Facility	(except for removal of all extractions of teeth, which are not covered for all places of service)(except for penile implants which are not covered for all places of service)	95% after deductible	85% after deductible	70% after deductible
Surgical Services - Diagnostic Endoscopic Services		95% after deductible	85% after deductible	70% after deductible
Outpatient Therapy				
Cardiac Rehabilitation		95% after deductible	85% after deductible	70% after deductible
Chemotherapy		95% after deductible	85% after deductible	70% after deductible
Chiropractic	(35 visits per benefit period)	$15 copay, then 100%	$25 copay, then 100%	Not Covered
Dialysis Treatment		95% after deductible	85% after deductible	70% after deductible
Hyperbaric Therapy		95% after deductible	85% after deductible	70% after deductible
Occupational Therapy	(35 visits per benefit period, combined with Physical Therapy and Speech Therapy)	95% after deductible	85% after deductible	70% after deductible
Physical Therapy	(35 visits per benefit period, combined with Occupational Therapy and Speech Therapy)	95% after deductible	85% after deductible	70% after deductible
Pulmonary Therapy		95% after deductible	85% after deductible	70% after deductible
Radiation Therapy		95% after deductible	85% after deductible	70% after deductible
Respiratory Therapy		95% after deductible	85% after deductible	70% after deductible
Speech Therapy	(35 visits per benefit period, combined with Physical Therapy and Occupational Therapy)	95% after deductible	85% after deductible	70% after deductible
Preventive Government Mandated Benefits				
Health Care Reform Preventive Benefits		100%	100%	70% after deductible
Health Care Reform Preventive Benefits for Women		100%	100%	70% after deductible

Subcategory	Variable	Tier 1	Tier 2	Tier 3
Preventive Exams and Immunizations				
Exam Associated with Pap Test	(age 21 and over, 1 per benefit period)	100%	100%	70% after deductible
Family Planning Exam	(age 21 and over, 1 per benefit period)	100%	100%	70% after deductible
Hearing Exam		Not Covered	Not Covered	Not Covered
Immunizations	(All Immunizations)	100%	100%	70% after deductible
Physical Exam	(age 21 and over; 2 per benefit period)	100%	100%	70% after deductible
Vision Exam	(age 21 and over; 1 per benefit period)	$15 copay, then 100%	$25 copay, then 100%	Not Covered
Preventive Tests				
Bone Density Tests		100%	100%	70% after deductible
Colon Cancer Screening		100%	100%	70% after deductible
Preventive Endoscopic Services		100%	100%	70% after deductible
Lab		100%	100%	70% after deductible
Mammogram	(1 per benefit period)	100%	100%	70% after deductible
Medical Tests		100%	100%	70% after deductible
Pap Test	(1 per benefit period)	100%	100%	70% after deductible
X-rays		100%	100%	70% after deductible
Well Child Care				
Covered up to the age of		21		
Maximum		Unlimited		
Exams		100%	100%	70% after deductible
Family Planning Exams		100%	100%	70% after deductible
Hearing Exams		100%	100%	70% after deductible
Immunizations	(All Immunizations)	100%	100%	70% after deductible
Labs		100%	100%	70% after deductible
Vision Exams		100%	100%	70% after deductible
Additional Services				
Abortions - Elective		Not Covered	Not Covered	Not Covered
Abortions - Therapeutic		95% after deductible	85% after deductible	70% after deductible
Acupuncture		Not Covered	Not Covered	Not Covered
Ambulance		N/A	85% after deductible	85% after deductible
Approved Clinical Trial		Benefits paid based on services rendered		
Autism Spectrum Disorders (other than ABA)	(Unlimited (all ages) effective 1/1/2024)	Benefits paid based on services rendered		
Applied Behavior Analysis(ABA)	Unlimited (all ages)	Benefits paid based on services rendered		

Subcategory	Variable	Tier 1	Tier 2	Tier 3
Blood, Blood Typing and Administration		95% after deductible	85% after deductible	70% after deductible
Durable Medical Equipment		95% after deductible	85% after deductible	70% after deductible
Gender Affirming Surgery		Benefits paid based on services rendered		
Hospice		N/A	85% after deductible	70% after deductible
Infertility Treatment	($15,000 per benefit period)(The coinsurance does not apply to the coinsurance out-of-pocket limit(s) or pay at 100% after the limit(s) is/are met.)In Vitro Fertilization and Artificial Insemination - Medically Necessary and Routine	70% after deductible; The coinsurance does not apply to the coinsurance out-of-pocket limit(s) or pay at 100% after the limit(s) is/are met.	70% after deductible; The coinsurance does not apply to the coinsurance out-of-pocket limit(s) or pay at 100% after the limit(s) is/are met.	Not Covered
Medical Supplies		95% after deductible	85% after deductible	70% after deductible
Non-emergency care when traveling outside the United States		Not Covered	Not Covered	Not Covered
Oral Accident		95% after deductible	85% after deductible	70% after deductible
Organ Transplant		95% after deductible	85% after deductible	Not Covered
Private Duty Nursing		Not Covered	Not Covered	Not Covered
TMJ	(TMJ Appliance is Not Covered)	Benefits paid based on services rendered		
Urgent Care Providers	(all preventive services including exams, immunizations, and diagnostics)	Not Covered	Not Covered	Not Covered
Weight Loss Surgical Services (Bariatric Surgery)	(limited to $50,000 per lifetime)	70% after deductible	Not Covered	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.

Drug

Subcategory	Variable	
General Information		
Product		Realtime Processing - External PBMs
Pharmacy Benefits Manager (PBM)		Cerpass RX

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