The University of Toledo

Medical Mutual SuperMed

Gold Plan 2025

GOLD PLAN	Tier 1 — UToledo Health	Tier 2 — In-Network (Medical Mutual SuperMed in Ohio, CIGNA outside Ohio)	Tier 3 — Out-of-Network (may be balanced bill)
EMBEDDED DEDUCTIBLE			
Single	$150	$300	$1,000
Single+1 OR Family	$300	$600	$2,000
Coinsurance	95% after ded.	85% after ded.	70% after ded.
Maximum Out of Pocket			
Single	$1,250	$2,500	$4,000
Single+1 OR Family	$2,500	$5,000	$8,000
Deductible and Out of Pocket Satisfactions	Tier 1 ded./OOP satisfies Tier 1 and 2	Tier 2 ded./OOP satisfies Tier 1 and 2	Tier 3 ded./OOP satisfies Tier 1,2,3
Physician/Office Services			
Preventive Health Services	Covered in full, not subject to deductible	Covered in full, not subject to deductible	70% after ded.
Office Visit	$15 copay per visit	$25 copay per visit	70% after ded.
Specialist Visit	$30 copay per visit	$40 copay per visit	70% after ded.
Podiatry Services	$30 copay per visit	$40 copay per visit	70% after ded.
Routine Vision Exam	$15 copay, once per calendar year	$25 copay , once per calendar year	70% after ded.
OB/GYN Visits (Non Preventive)	$15 copay per visit	$25 copay per visit	70% after ded.
Annual GYN Visit (Preventive)	Covered in full, not subject to deductible	Covered in full, not subject to deductible	70% after ded.
Chiropractic Services (35 visits per member per year)	$15 copay	$25 copay	Not covered
Infertility Services — does not apply to max out of pocket	70% after ded., up to $15,000 per calendar year	70% after ded., up to $15,000 per calendar year	Not covered
Diagnostics			
Diagnostic Test (X-ray, lab)	95% after ded.	85% after ded.	70% after ded.
Imaging (CT/PET scans, MRI's) †PA	95% after ded.	85% after ded.	70% after ded.
Maternity Care			
Prenatal and Postnatal	N/A	Covered in full, not subject to deductible	70% after ded.
Delivery	N/A	85% after ded.	70% after ded.
Hospital Services			
Inpatient †PA	95% after ded.	$100 copay per admission then 85% after ded.	$250 copay per admission then 70% after ded.
Outpatient	95% after ded.	85% after ded.	70% after ded.
Emergency Room Facility	$200 copay per visit (waived if admitted)	$200 copay per visit (waived if admitted)	$200 copay per visit (waived if admitted)
Urgent Care	N/A	$50 copay per visit	$50 copay per visit
Durable Medical Equipment (subject to Medicare Part B) †PA	95% after ded.	85% after ded.	70% after ded.
Foot Orthotics (subject to Medicare Part B Guidelines) †PA	N/A	85% after ded.	70% after ded.
Prosthetic Devices †PA	N/A	85% after ded.	70% after ded.
Human Organ Transplant †PA	95% after ded.	85% after ded.	Not covered
Bariatric Treatment*	95% after ded.	N/A	N/A
Bariatric Surgery*	70% after ded.	N/A	N/A
Ambulance			
Emergency Use	N/A	85% after ded.	85% after ded.
Outpatient Surgical Facility Services			
Including Outpatient Surgery Facility Charge	95% after ded.	85% after ded.	70% after ded.
Therapy Services			
Inpatient Rehabilitation †PA up to 60 days per member per calendar year	95% after ded.	85% after ded.	70% after ded.
Outpatient Physical/Occupational/Speech Therapy up to 35 visits per member, per calendar year (combined)	95% after ded.	85% after ded.	70% after ded.
Skilled Nursing Facility			
120 day limit per member, per calendar year †PA	95% after ded.	85% after ded.	70% after ded.
Hospice/Home Health Care			
In Lieu of Hospitalization †PA	N/A	85% after ded.	70% after ded.
Mental Health/Substance Abuse			
Office Visit, Specialist, Inpatient, Outpatient	Based on service type	Based on service type	Based on service type

**$50,000 lifetime maximum for bariatric services.*

Visit **medmutual.com** and login to My Health Plan for provider search and tier level.

†PA — Prior Authorization Required

Updated 10/01/2024