Trumbull County School Consortium
Benefit Comparison Sheet

	SuperMed Plus I		SuperMed Plus II		SuperMed Plus III		SuperMed Plus IV	
	SuperMed Hospital and SuperMed Plus Physicians must be used	Any Hospital and Physician can be used	SuperMed Hospital and SuperMed Plus Physicians must be used	Any Hospital and Physician can be used	SuperMed Hospital and SuperMed Plus Physicians must be used	Any Hospital and Physician can be used	SuperMed Hospital and SuperMed Plus Physicians must be used	Any Hospital and Physician can be used
BENEFIT DESCRIPTION	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Benefit Period	January 1st through December 31st		January 1st through December 31st		January 1st through December 31st		January 1st through December 31st	
Dependent Age	26 Removal upon End of Month		26 Removal upon End of Month		26 Removal upon End of Month		26 Removal upon End of Month	
Pre-Existing Condition Waiting Period	Not Applicable		Not Applicable		Not Applicable		Not Applicable	
Blood Pint Deductible	0 Pints		0 Pints		0 Pints		0 Pints	
Overall Annual Benefit Period Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
Benefit Period Deductible - Single/Family	$100 / $200	$200 / $400	$350 / $700	$500 / $1,000	$1,100 / $2,200	$2,000 / $4,000	$1,500 / $3,000[4]	$3,000 / $6,000[4]
Coinsurance	90%	80%	80%	60%	80%	60%	80%	60%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$300 / $600	$1,000 / $2,000	$1,000 / $2,000	$3,500 / $7,000	$4,000 / $8,000	$8,000 / $16,000	$1,500 / $3,000[4]	$3,000 / $6,000[4]
Out of Pocket Maximum (Deductible + Coinsurance) Single/Family	$400 / $800	$1,200 / $2,400	$1,350 / $2,700	$4,000 / $8,000	$5,100 / $10,200	$10,000 / $20,000	$3,000 / $6,000[4]	$6,000 / $12,000[4]
Maximum Out of Pocket Maximum (Deductible + Coinsurance + Medical & Drug Copays) Single/Family	$6,600 / $13,200	Not Applicable	$6,600 / $13,200	Not Applicable	$6,600 / $13,200	Not Applicable	$3,000 / $6,000[4]	Not Applicable
Physician/Office Services								
Office Visit (Illness/Injury)[1]	$20 copay, then 100%	80% after deductible	$20 copay, then 100%	60% after deductible	$30 copay, then 100%	60% after deductible	80% after deductible	60% after deductible
Urgent Care Facility Services[1]	$20 copay, then 100%	80% after deductible	$20 copay, then 100%	60% after deductible	$30 copay, then 100%	60% after deductible	80% after deductible	60% after deductible
All Immunizations	100%	80% after deductible	100%	60% after deductible	100%	60% after deductible	100%	60% after deductible
Routine / Preventative Services								
Routine Physical Exams (ages 21 and over)	100%	80% after deductible	100%	60% after deductible	100%	60% after deductible	100%	60% after deductible
Well Child Care Services (to age 21)	100%	80% after deductible	100%	60% after deductible	100%	60% after deductible	100%	60% after deductible
Routine Annual Mammogram (One Per Benefit Period)	100%	80% after deductible	100%	60% after deductible	100%	60% after deductible	100%	60% after deductible
Routine Annual Pap Test (One Per Benefit Period)	100%	80% after deductible	100%	60% after deductible	100%	60% after deductible	100%	60% after deductible
Routine Laboratory, X-ray and Diagnostic Medical Tests	100%	80% after deductible	100%	60% after deductible	100%	60% after deductible	100%	60% after deductible
Routine Endoscopic Services	100%	80% after deductible	100%	60% after deductible	100%	60% after deductible	100%	60% after deductible
Routine Annual Vision Exam (One Per Benefit Period, Age 21 and over)	$25 copay, then 100%	50% after deductible	$25 copay, then 100%	50% after deductible	$30 copay, then 100%	50% after deductible	100%	60% after deductible
Routine Annual Hearing Exam (One Per Benefit Period, Age 21 and over)	$25 copay, then 100%	50% after deductible	$25 copay, then 100%	50% after deductible	$30 copay, then 100%	50% after deductible	100%	60% after deductible
Outpatient Services								
Surgical Services	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Diagnostic X-rays, Lab & Medical Tests	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Chemotherapy (includes oral) & Radiation Therapy	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Physical Therapy & Chiropractic Services combined (60 visits per benefit period)	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Inhalation, Pulmonary & Respiratory Therapies	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Occupational Therapy (10 visits then subject to Medical Review)	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Speech Therapy (10 visits then subject to Medical Review)	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Cardiac Rehabilitation	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Emergency use of an Emergency Room	$100 copay, then 90% after deductible		$100 copay, then 80% after deductible		$100 copay, then 80% after deductible		80% after deductible	
Non-Emergency use of an Emergency Room	after deductible	80% after deductible	after deductible	60% after deductible	after deductible	60% after deductible	80% after deductible	60% after deductible

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BENEFIT DESCRIPTION	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Inpatient Facility								
Semi-Private Room and Board	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Maternity	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Skilled Nursing Facility (180 days per benefit period)	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Additional Services								
Allergy Testing and Treatments	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Ambulance - Air if medically necessary	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Weight Loss Surgery ($30,000 Lifetime Maximum)	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Durable Medical Equipment & Medical Supplies including Jobst/Elastic Stockings	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Home Healthcare (180 visits per benefit period)	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Hospice	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Human Organ Transplants	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Private Duty Nursing	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Newborn Exam	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
TMJ Services	90% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Mental Health and Substance Abuse								
Inpatient Mental Health and Substance Abuse Services	**Benefits paid are based on corresponding medical benefits**		**Benefits paid are based on corresponding medical benefits**		**Benefits paid are based on corresponding medical benefits**		**Benefits paid are based on corresponding medical benefits**	
Outpatient Mental Health and Substance Abuse Services								
PRESCRIPTION DRUGS COVERED THROUGH CAREMARK EFFECTIVE 01/01/18								
Retail Copay (30 day supply)	**Retail Copay (30 day supply)**		**Retail Copay (30 day supply)**		**Retail Copay (30 day supply)**		**Retail Copay (30 day supply)**	
Generic	$5		$5		$5		80% after deductible	
Preferred Brand	$20		$20		$20		80% after deductible	
Non-Preferred Brand	$35		$35		$35		80% after deductible	
Mail Order Copay (90 day supply)	**Mail Order Copay (90 day supply)**		**Mail Order Copay (90 day supply)**		**Mail Order Copay (90 day supply)**		**Mail Order Copay (90 day supply)**	
Generic	$10		$10		$10		80% after deductible	
Preferred Brand	$40		$40		$40		80% after deductible	
Non-Preferred Brand	$70		$70		$70		80% after deductible	
ADDITIONAL ITEMS								
Minimum Employee Contributions[3]	5% Minimum Employee Contribution		10% Minimum Employee Contribution		0% Employee Contribution		0% Employee Contribution	
Flex Savings Account	$2,500 Maximum		$2,500 Maximum		$2,500 Maximum		Not Available	
Health Reimbursement Account - Single / Family	Not Applicable		$100 / $200		$500 / $1,000		Not Available	

[1] The office visit copay applies to the cost of the office visit only.

[2] Copay waived if admitted. The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance.

[3] Employee Contributions differ by school but must meet minimum percentage listed.

[4] Entire family deductible must be met before benefits are provided for any family members and entire family coinsurance Out of Pocket maximum must be met before benefits are paid at 100%.

This benefit summary provides a brief outline of the services covered by Medical Mutual. Refer to your certificate for information regarding the administration of the plan. When your coverage becomes effective, you will receive a Group Insurance certificate describing your coverage in greater detail. The complete terms of coverage will be governed by the group insurance contract.