



**Olentangy Local School District  
SuperMed Plus  
Effective 1/1/2011**



<b>Benefits</b>	<b>Network</b>	<b>Non-Network</b>
Benefit Period	January 1 <sup>st</sup> through December 31 <sup>st</sup>	
Dependent Age Limit	26	
Older Aged Child	28	
	Removal End of Month	
Pre-Existing Condition Waiting Period (Does not apply to members under the age of 19)	Initial Waiver; All others 3 -12	
Overall Annual Benefit Period Maximum	Unlimited	
Blood Pint Deductible	0 pints	
Benefit Period Deductible – Single/Family <sup>1</sup>	None	\$200 / \$400
Coinsurance	100%	80%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) – Single/Family	None	\$500 / \$1,000
<b>Physician/Office Services</b>		
Office Visit (Illness/Injury) <sup>2</sup>	\$10 copay, then 100%	80% after deductible
Urgent Care Office Visit <sup>2</sup>	\$10 copay, then 100%	80% after deductible
All Immunizations	100%	80% after deductible
Allergy Testing	\$10 copay, then 100%	80% after deductible
Allergy Treatment	100%	80% after deductible
<b>Preventative Services – in accordance with State and Federal Law<sup>4</sup></b>		
Routine Physical Exam (Ages 21 and over) <sup>2</sup>	100%	50% after deductible <sup>3</sup>
Well Child Care Services including Exam , Routine Vision, Routine Hearing Exams, Well Child Care Immunizations and Laboratory Tests ( To age 21)	100%	80% after deductible
Routine Vision Exams <sup>2</sup> (One every two benefit periods)	100%	\$10 copay, then 100%
Routine Hearing Exams <sup>2</sup> (One every two benefit periods)	100%	50% after deductible <sup>3</sup>
Routine Pap Test	100%	80% after deductible
Routine Mammogram (1/yr)	100%	80% after deductible
Routine Lab, X-ray and Medical Testing	100%	50% after deductible <sup>3</sup>
Routine Endoscopic Services	100%	50% after deductible <sup>3</sup> (Professional); 80% after deductible (Institutional)
<b>Outpatient Services</b>		
Surgical Services	100%	80% after deductible
Diagnostic Services	100%	80% after deductible
Physical, Occupational, Speech, and Chiropractic Therapies (60 combined visit per benefit period)	100%	80% after deductible
Cardiac Rehabilitation	100%	80% after deductible
Emergency use of an Emergency Room <sup>5</sup>	\$50 copay, then 100%	
Non-Emergency use of an Emergency Room <sup>5,6</sup>	\$50 copay, then 100%	\$50 copay, then 80%
<b>Inpatient Facility</b>		
Semi-Private Room and Board	100%	80% after deductible
Maternity	100%	80% after deductible
Skilled Nursing Facility (100 days per benefit period)	100%	80% after deductible
<b>Additional Services</b>		
Ambulance	100%	80% after deductible

<b>Benefits</b>	<b>Network</b>	<b>Non-Network</b>
Durable Medical Equipment	100%	80% after deductible
Elective Abortions	NOT COVERED	NOT COVERED
Home Healthcare (60 visits per benefit period)	100%	80% after deductible
Hospice	100%	80% after deductible
Jobst Stockings (4 pairs per benefit period)	100%	80% after deductible
Mastectomy Bras (2 per benefit period)	100%	80% after deductible
Organ Transplants	100%	80% after deductible
Private Duty Nursing	100%	80% after deductible
Residential Treatment Centers	100%	80% after deductible
Services billed for a Diagnosis of Obesity (including but not limited to Weight Loss Surgical Services and complications)	NOT COVERED	NOT COVERED
TMJ Services (\$1,000 lifetime maximum)	100%	80% after deductible
<b>Mental Health and Substance Abuse – Federal Mental Health Parity</b>		
Inpatient Mental Health and Substance Abuse Services	Benefits paid are based on corresponding medical benefits	
Outpatient Mental Health and Substance Abuse Services		

Note: Services requiring a copayment are not subject to the single/family deductible.

Non-Contracting and Facility Other Providers will pay the same as Non-Network.

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. No person other than 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.

<sup>1</sup>Maximum family deductible. Member deductible is the same as single deductible. 3-month carryover applies.

<sup>2</sup>The office visit copay applies to the cost of the office visit only.

<sup>3</sup>Not applied to Coinsurance Out-of-Pocket Maximum.

<sup>4</sup>Preventative services include evidence-based services that have a rating of "A" or "B" in the United States Preventative Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.

<sup>5</sup>Copay waived if admitted.

<sup>6</sup>The copay applies to room charges only. All other covered charges are subject to deductible and coinsurance.