Mt. Gilead Exempted School District

2023
Employee Benefits

Medical Benefits

Your medical benefits will be provided by Medical Mutual SuperMed.
Below are a few highlights that the medical plan offers.
Please reference full benefit certificates for more detailed descriptions.

Plan 1 PPO $500 Deductible

	In Network Single / Family	Out of Network Single / Family
Lifetime Maximum	Unlimited	
Deductibles (Embedded)	$500 / $1,000	$1,000 / $2,000
Coinsurance % paid by Insured	20%	50%
Coinsurance & Ded. Max. per yr.	$2,000 / $4,000	$3,000 /$ 6,000
Maximum Out of Pocket (MOOP)	$2,500 / $5,000	$5,500 / $10,000
Office visit Copay for:		
Primary Doctor	20% Coinsurance	50% Coinsurance
Preventative / Routine Care	$0 Copayment, not subject to deductible	50% After deductible
Specialist	20% Coinsurance	50% Coinsurance
Immunizations	$0 Copayment, not subject to deductible	50% Coinsurance
Mental Health Office Services	20% Coinsurance	50% Coinsurance
Substance abuse	20% Coinsurance	50% Coinsurance
Urgent Care	20% Coinsurance	50% Coinsurance
Emergency Room	20% Coinsurance	
Ambulance services	20% Coinsurance after Ded	
In/Outpatient hospital services	20% Coinsurance	50% Coinsurance
Hospital Services	20% Coinsurance	50% Coinsurance
Maternity	20% After deductible	50% After deductible
Semi-Private Room & Board	20% After deductible	50% After deductible
Physician services	20% After deductible	50% After deductible
Inpatient & Outpatient Surgery	20% Coinsurance	50% Coinsurance
Prescription Drugs (30 day retail)	25% after deductible	See Certificate of Coverage
Out of Pocket Maximum	$3,000 / $5,000	See Certificate of Coverage
Mail Order-90 days (except tier 4)	25% after deductible	See Certificate of Coverage
Specialty Drugs (tier 4)	25%, or the maximum of any available manufacturer funded Copay assistance.	

DELTA DENTAL

Delta Dental PPO™ (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 10197-0001
Mount Gilead Exempted Village Schools

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan - Delta Dental of Ohio

Benefit Year - January 1 through December 31

Covered Services -

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment - to temporarily relieve pain	100%	100%	100%
Sealants - to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services - fillings and crown repair	80%	80%	80%
Endodontic Services - root canals	80%	80%	80%
Periodontic Services - to treat gum disease	80%	80%	80%
Oral Surgery Services - extractions and dental surgery	80%	80%	80%
Other Basic Services - misc. services	80%	80%	80%
Relines and Repairs - to prosthetic appliances	80%	80%	80%
Major Services			
Major Restorative Services - crowns	50%	50%	50%
Prosthodontic Services - bridges, implants, dentures, and crowns over implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	75%	75%	75%
Orthodontic Age Limit -	No Age Limit	No Age Limit	No Age Limit

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

Maximum Payment - $1,500 per person total per Benefit Year on all services except orthodontic services. $1,500 per person total per lifetime on orthodontic services.

Payment for Orthodontic Service - When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 75% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by your Dentist to Delta Dental.

Deductible - None.

Mount Gilead Schools

40%OFF

additional complete pair of prescription eyeglasses

20%OFF

non-covered items, including non-prescription sunglasses

Find an eye doctor
(Insight Network)

- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads up
You may have additional benefits. Log into eyemed.com/member to see all plans included with your benefits.

SUMMARY OF BENEFITS		
VISION CARE SERVICES	**IN-NETWORK MEMBER COST**	**OUT-OF-NETWORK MEMBER REIMBURSEMENT**
EXAM SERVICES		
Exam	$5 copay	Up to $40
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit & Follow-up - Standard	Up to $40; contact lens fit and two follow-up visits	Not covered
Fit & Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	$0 copay; 20% off balance over $120 allowance	Up to $84
STANDARD PLASTIC LENSES		
Single Vision	$10 copay	Up to $30
Bifocal	$10 copay	Up to $50
Trifocal	$10 copay	Up to $70
Lenticular	$10 copay	Up to $70
Progressive - Standard	$65 copay	Up to $50
Progressive - Premium Tier 1 - 4	$95 - 185 copay	Up to $50
LENS OPTIONS		
Anti Reflective Coating - Standard	$45 copay	Up to $5
Anti Reflective Coating - Premium Tier 1 - 3	$57 - 85 copay	Up to $5
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$40	Not covered
Polycarbonate - Standard < 19 years of age	$0 copay	Up to $5
Scratch Coating - Standard Plastic	$0 copay	Up to $5
Tint - Solid or Gradient	$0 copay	Up to $5
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $150 allowance	Up to $105
Contacts - Disposable	$0 copay; 100% of balance over $150 allowance	Up to $105
Contacts - Medically Necessary	$0 copay; paid-in-full	Up to $210
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing exam and aids; call 1.877.203.0675	Not covered
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

FREQUENCY	**ALLOWED FREQUENCY - ADULTS**	**ALLOWED FREQUENCY - KIDS**
Exam	Once every plan year	Once every plan year
Frame	Once every plan year	Once every plan year
Lenses	Once every plan year	Once every plan year
Contacts Lenses	Once every plan year	Once every plan year

(Plan allows member to receive either contacts and frame, or frame and lens services)

OneAmerica / AUL

Basic Life & AD&D
and
Voluntary Term Life Insurance

		Life Insurance amounts will be determined by the employee classification
Base Life and AD&D Insurance: **Premiums are 100% paid by the Board of Education, however employees may be required to pay taxes on premiums for life insurance amounts over $50,000.**	Full Time Eligible Employees	**Class 001 (Superintendent)** - Two times the Annual Base Salary. **Class 002 (Treasurer)** - Two times the Annual Base Salary. **Class 003 (Administration)** - Two times the Annual Base Salary. **Class 004 - (All Other Eligible Employees)** -$50,000.
VOLUNTARY Life and AD&D **VOLUNTARY SPOUSE LIFE AND AD&D:** *Child(ren) - 6 months to under 26 years *Child(ren) - Live birth to under 6 months Guaranteed Amount $10,000	Minimum: $10,000 Maximum Amount: $300,000 not to exceed 5 times employees' annual salary Option 1: Spouse = $5,000 Child(ren) = $2,500 Option 2: Spouse = $10,000 Child(ren) = $5,000 Option 3: Spouse = $15,000 Child(ren) = $7,500 Option 4: Spouse = $20,000 Child(ren) = $10,000	Guaranteed Issue Amount $200,000 Guarantee Issue Amount: Spouse = $20,000 Children = $10,000 *Guaranteed Amount of coverage is available without having to answer ANY health questions if elected within 31 days of eligibility.*

Contact Information

Medical
Medical Mutual of Ohio
Policy #615235
Customer Service: (800) 272-6967
Member Portal: www.mmoh.com

Dental
Delta Dental
Policy #10197-0001
Customer Service: (800) 524-0149
www.DeltaDentalOH.com

Vision
EyeMed
Policy #1031899-1001
Customer Service: (866) 800-5457

Life and Disability
American United Life Insurance Company
Policy #00610712-0180
(800) 553-5318

Voluntary Life
American United Life Insurance Company
Policy #G 00610712-0180
(800) 553-5318

Educators Consulting Services
Steve Fate
614.890.7373 ext. 115
sfate@educatorscs.com

Susan Maynard
614-890-7373 ext. 107
susan@nubgroup.com

****This benefit brochure is for illustrative purposes only. Please refer to the Certificate of Coverage for actual benefits and coverages.**

ECS EDUCATORS CONSULTING SERVICES, LLC

National United Brokers, Inc.