Insurance

Current Medical Mutual rates in effect for 2026 through 2027 for Certified Staff are as follows:

	Healthcare Rates	Employee Contribution Monthly
Single	$874.64	$131.20
Employee + Spouse	$1,737.35	$260.61
Employee + Children	$1,582.28	$237.35
Family	$2,255.33	$338.30

Current ICHRA rates in effect for 2026 for Classified Staff are as follows:

UH Based	Healthcare Rates	Employee Contribution Monthly
Single	$672.01	$100.80
Employee + Spouse	$1,334.56	$200.18
Employee + Children	$1,215.46	$182.32
Family	$1,732.35	$259.85

CCF Based	Healthcare Rates	Employee Contribution Monthly
Single	$911.30	$340.09
Employee + Spouse	$1,809.75	$675.37
Employee + Children	$1,648.24	$615.10
Family	$2,349.18	$876.68

The School District purchases a high deductible insurance plan. The plan covers major medical and prescription coverage. The District then funds the employee claims as they occur through a 3rd party administrator: Barrett Benefits.

The current plans have deductibles as follows for inside network:

	Deductible	Max Out of Pocket	Reimbursement Deductible
Single:	$5,000/$8,050	$1,000	$ 500
Family:	$10,000/$16,100	$2,000	$1,000

Once the employee reaches the reimbursement deductible, Barrett Benefits reimburses the employee directly 80% of their carrier approved claim cost until they reach the max out of pocket and then Barrett will reimburse 100% of the employee claims. The maximum out of pocket that an employee will pay is Single: $1,000 and Family: $2,000. After the deductible is reached, Berkshire pays 100% towards claims. Medical Mutual Out of Network claims are subject to network prices and the out of network deductibles. The IHCRA does not allow for out of network claims. Co-pays are not applied towards deductibles.

Claims can be processed by Barrett Benefits two ways:

1. You can fax or mail your Explanation of Benefits (EOB) to Barrett at:
   Fax (866) 539-5643
   Mail to: Barrett Benefits
   593 Broadway Ave
   Cleveland OH 44146
   (866) 845-8600 Option 1
   Sharefund@bbginc.net

2. You can complete an Authorization that will allow Barrett Benefits to retrieve your EOBs from your insurance coverage from their website on a weekly basis.

Prescription Drug Reimbursements require that you submit a copy of the pharmacy tag (usually comes stapled to your prescription) and the receipt to Barrett Benefits. Prescription reimbursements expire 6 months after receipt of payment date.

Any questions regarding claims for Barrett Benefits can be emailed to Kathy Salsbury at ksalsbury@bbginc.net or she can be reached by phone at (866) 845-8600 Option 1

The Treasurer's office, once a week, receives a list of claims that will be paid by Barrett Benefits. The Treasurer's office does not see any claim detail, they only see the employee's name and a dollar amount. The Treasurer's office then forwards payment to Barrett Benefits, and they in turn process a check to the employee.

Please note Barrett Benefits is a licensed 3rd party administrator through the State of Ohio. Barrett Benefits is subject to strict audit and bonding requirements from the State of Ohio. Your claims are held in the strictest confidence and actual claims are never seen by staff in the Treasurer's Office.

Dental Insurance

Dental Insurance is provided by Superior Dental Care. The Berkshire Board of Education pays the premiums with zero out of pocket contribution costs from Berkshire Schools' employees.

Optical Insurance

Classified Employees are entitled to a $450.00 yearly reimbursement for optical expenses incurred by an employee or employee's eligible dependents. Original receipts must be attached to the Optical Reimbursement form located in your myscview.com account, then submitted to the Treasurer's office for reimbursement.

Optical Insurance is provided by EyeMed for all Certificated Employees. Employees contribution is 15% of the Board's premium. The current plan provides for in network copay amounts and out of network reimbursed amounts.

Life Insurance

Life insurance coverage is available to employees of the District. Employees should consult their negotiated agreement for coverage amounts.

Important Dates

Medical Insurance Coverage Period: Coverage Year – January 1 through December 31

Dental Insurance Coverage Period: Coverage Year – January 1 through December 31

Vision Reimbursement & Coverage Period: Coverage Year – January 1 through December 31

Flexible Savings Account: January 1st through December 31,with a grace period until March 15

Waiver Deadline: August 25th of the new School Year

Waiver Payment: The First pay date in September of the following year.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 800-585-2583. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other underlined terms see the Glossary. You can view the Glossary at MedMutual.com/SBC or call 800-585-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$5,000**/single,**$10,000**/family Network **$10,000**/single,**$20,000**/family Non-Network	Generally, you must pay all of the costs from providers up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible.**
Are there services covered before you meet your deductible?	**Yes. Certain preventive care and all services with copayments are covered and paid by the plan before you meet your deductible.**	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive service**s at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**$6,600**/single,**$13,200**/family Network **$20,000**/single,**$40,000**/family Non-Network	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Certain **specialty drugs**, **premiums**, balance-billed charges and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Will you pay less if you use a network provider?	Yes, See MedMutual.com/SBC or call 800-585-2583 for a list of participating providers.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**). Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No	You can see the **specialist** you choose without a **referral.**

All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. Services with **copayments** are covered before you meet your **deductible**, unless otherwise specified.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	None
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care/ screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray)	20% coinsurance	50% coinsurance	None
	Diagnostic test (blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None

[For more information about limitations and exceptions, see the plan or policy document at MedMutual.com/SBC.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at MedMutual.com/SBC	Generic copay - retail Tier 1	$10 after deductible	See Plan Documents for Details	Covers up to a 30-day supply.
	Generic copay - home delivery Tier 1	$25 after deductible	See Plan Documents for Details	Covers up to a 90-day supply.
	Preferred brand copay - retail Tier 2	$50 after deductible	See Plan Documents for Details	Covers up to a 30-day supply.
	Preferred brand copay - home delivery Tier 2	$125 after deductible	See Plan Documents for Details	Covers up to a 90-day supply.
	Non-preferred brand copay - retail Tier 3	$90 after deductible	See Plan Documents for Details	Covers up to a 30-day supply.
	Non-preferred brand copay - home delivery Tier 3	$225 after deductible	See Plan Documents for Details	Covers up to a 90-day supply.
	Specialty drugs	30% up to $350 maximum after deductible or the max of any available manufacturer-funded copay assistance	See Plan Documents for Details	Covers up to a 30 day supply. Certain specialty drugs are considered non-essential health benefits and therefore do not apply to the out-of-pocket maximum. They will also be subject to higher cost-share.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees (Outpatient)	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% **coinsurance**		None
	Emergency medical transportation	20% **coinsurance**		None
	Urgent care	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	None
	Physician/ surgeon fee (inpatient)	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Benefits paid based on corresponding medical benefits		None
	Inpatient services	Benefits paid based on corresponding medical benefits		None

[For more information about limitations and exceptions, see the plan or policy document at MedMutual.com/SBC.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, copay, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	(100 days per benefit period, combined with Private Duty Nursing)
	Rehabilitation services (Physical Therapy)	20% coinsurance	50% coinsurance	(20 visits per benefit period)
	Habilitation services (Occupational Therapy)	20% coinsurance	50% coinsurance	(20 visits per benefit period)
	Habilitation services (Speech Therapy)	20% coinsurance	50% coinsurance	(20 visits per benefit period)
	Skilled nursing care	20% coinsurance	50% coinsurance	(150 days per benefit period, combined with Physical Medicine and Rehabilitation)
	Durable medical equipment	50% **coinsurance**		None
	Hospice services	20% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	None
	Children's glasses	Not Covered		Excluded Service
	Children's dental check-up	Not Covered		Excluded Service

[For more information about limitations and exceptions, see the plan or policy document at MedMutual.com/SBC.]

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Children's dental check-up
- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends.The contact information for those agencies is: your state insurance department at 800-686-1526 and the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your state insurance department at 800-686-1526 or your plan at 800-585-2583.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

----------*To see examples of how this plan might cover costs for sample medical situations, see the next section*----------

The coverage example numbers assume that the patient does not use an HRA or FSA. If you participate in an HRA or FSA and use it to pay for out-of-pocket expenses, then your costs may be lower.

[For more information about limitations and exceptions, see the plan or policy document at MedMutual.com/SBC.]

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$5,000**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$10
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,570**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$5,000**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,050**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$5,000**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 800-585-2583.

The plan would be responsible for the other costs of these EXAMPLE covered services.

[For more information about limitations and exceptions, see the plan or policy document at MedMutual.com/SBC.]

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MEDICAL MUTUAL'S CUSTOMER CARE DEPARTMENT AT 1-800-382-5729.

Nondiscrimination Notice

Medical Mutual of Ohio complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Medical Mutual does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Medical Mutual provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Medical Mutual provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or if you believe Medical Mutual failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator
Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- Electronically through the Office for Civil Rights Complaint Portal available at:
  ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW Room 509F
  HHH Building
  Washington, DC 20201-0004
- By phone at:
  (800) 368-1019 (TDD: (800) 537-7697)
- Complaint forms are available at:
  hhs.gov/ocr/office/file/index.html

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or Consumers Life Insurance Company.

Individual and Family Insurance

Bronze $9,500 OFF-EX

Benefit Period: January 1 (or plan effective date) through December 31

Featured Offers

On-Demand Telehealth	As Low As
Enjoy easy access to care with on-demand telehealth visits for a $0 copay and virtual mental healthcare options for the same copay as an in-network office visit. You can visit live with a provider using a computer or mobile device. Virtual visits are a great time-saver when you need help for common health conditions like allergies and the flu or want to attend a therapy session from the comfort of your home. Log on to My Health Plan to view on-demand telehealth providers in your network.	**$0**

Select Preventive Generic Drugs	As Low As
In addition to a healthy lifestyle, getting preventive care and taking prescribed medications can be an important step in maintaining good health. Enjoy select preventive generic medications for as low as $0.	**$0**

Programs and Discounts to Support Your Health	You Pay
As a Medical Mutual member, you will have access to a variety of wellness programs and discounts to support your health, including health coaching to help manage chronic conditions, a Tobacco Quitline program, our MedMutual Maternity app for pregnancy-related tools and resources, and discounts on WeightWatchers® memberships—all for no additional cost.	**$0**

Wellness Program	Earn
Participate in our Med Mutual WELL program and earn a $50 e-gift card when certain health and wellness activities are completed. Select activities include an online health assessment, annual provider visit form, and a preventive care visit from the available options.	**$50**

Plan Essentials

Benefit	In-Network	Out-of-Network
Deductible	$9,500/$19,000[1]	Not Covered
Maximum Out-of-Pocket (MOOP) Includes deductibles, copays, RX drug copays and coinsurance	$9,500/$19,000[1]	Not Covered
Accumulation Method[1]	Embedded	Not Covered
Coinsurance Amount paid by member after the deductible is satisfied	0%	Not Covered
Overall Annual Benefit Period Max.	Unlimited	Not Covered
Dependent Age	Up to age 26	Not Covered
Benefit Period	January 1- December 31	Not Covered

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MEDICAL MUTUAL®

Benefit	In-Network	Out-of-Network
Physician Office Services		
Primary Care Physician (PCP) Office Visits	0% after deductible	Not Covered
Specialist Office Visits	0% after deductible	Not Covered
Urgent Care Office Visits	0% after deductible	Not Covered
On-Demand Telemedicine	$0 copay	Not Covered
Preventive Services		
Preventive Services Covered under PPACA	0%	Not Covered
Preventative Labs, X-rays and Tests (Non-PPACA)	0% after deductible	Not Covered
Preventive Immunizations (Non-PPACA)	0% after deductible	Not Covered
Preventive Prostate Specific Antigen (PSA)	0% after deductible	Not Covered
Routine Physical Exams	0%	Not Covered
Well Child Office Visits (Age 20 and Under)	0%	Not Covered
Pediatric Services (Age 18 and Under)		
Pediatric Dental	0%	Not Covered
Pediatric Dental Preventive Services	0%	Not Covered
Pediatric Dental Basic/Major Services	0%	Not Covered
Pediatric Dental Orthodontia Services (Medically Necessary)	0%	Not Covered
Pediatric Vision	0%	Not Covered
Pediatric Vision Hardware	0% after deductible	Not Covered
Outpatient Services		
Allergy Testing	0% after deductible	Not Covered
Cardiac Rehabilitation (36 visits/period)	0% after deductible	Not Covered
Chiropractic Services (12 visits/period)	0% after deductible	Not Covered
Diagnostic X-rays	0% after deductible	Not Covered
Diagnostic Lab	0% after deductible	Not Covered
Emergency Use of Emergency Room	0% after deductible	0% after deductible
Emergency Physician and Ancillary Services	0% after deductible	0% after deductible
Non-Emergency Use of Emergency Room	Not Covered	Not Covered
Mental Health & Substance Abuse Office Visits	0% after deductible	Not Covered
Occupational & Physical Therapy (20 visits each/period)	0% after deductible	Not Covered
Pulmonary Therapy (20 visits/period)	0% after deductible	Not Covered
Speech Therapy/Habilitation (20 visits/period)	0% after deductible	Not Covered
Surgery	0% after deductible	Not Covered
Inpatient Services		
Maternity/Obstetrics/Delivery	0% after deductible	Not Covered
Mental Health & Substance Abuse	0% after deductible	Not Covered
Physical Rehabilitation (60 days/period)	0% after deductible	Not Covered
Semi-Private Room and Board	0% after deductible	Not Covered
Skilled Nursing Facility (90 days/period)	0% after deductible	Not Covered
Surgery	0% after deductible	Not Covered
Organ Transplants	0% after deductible	Not Covered
Additional Services		
Ambulance	0% after deductible	Not Covered
Durable Medical Equipment and Medical Supplies	0% after deductible	Not Covered
Home Health Services (100 visits/period)	0% after deductible	Not Covered
Hospice	0% after deductible	Not Covered
Diagnostic Imaging (CT/PET/MRI)	0% after deductible	Not Covered

Benefit	In-Network	Out-of-Network
Prescription Drugs[3]		
Generic	Retail: 0% after deductible/30-day Supply Mail Order: 0% after deductible/90-day supply	Not Covered
Preferred Brand	Retail: 0% after deductible/30-day Supply Mail Order: 0% after deductible/90-day supply	Not Covered
Non-Preferred Brand	Retail: 0% after deductible/30-day Supply Mail Order: 0% after deductible/90-day supply	Not Covered
Specialty High-Cost	Retail: 0% after deductible /30-day supply	Not Covered

Notes

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.

Deductible/coinsurance expense incurred for services by a network provider will only apply to the network deductible/coinsurance out-of-pocket. Services received by a non-network or non-contracting provider will not be covered, except for emergency services.

Treatment for organ transplants must be pre-authorized and approved by Medical Mutual. If authorization is not received, and the transplant is not medically necessary/experimental/investigational, the recipient may be responsible for all billed charges. Unrelated Donor Search is $30,000 max/transplant. Transportation/meals/lodging is $10,000 max/transplant.

If you receive any amount of financial assistance from a coupon, patient assistance program, provider, pharmacy, etc. for the required cost share, that amount shall be considered an out-of-pocket expense and will not apply to deductibles and/or out of pocket maximums.

Footnotes

1. This product has an embedded accumulation applied.
Embedded Deductible: Any combination of family members may satisfy the family deductible. However, if one family member meets the individual amount, services will begin to pay for that particular family member.
Embedded Maximum Out-Of-Pocket: Any combination of family member may satisfy the family out-of-pocket, and services will pay at 100%. However, if one family member meets the individual amount, services will begin to pay for that particular family member.

2. Visits must be from an on-demand telehealth provider in your network. For a list of providers, visit My Health Plan at MedMutual.com/Member

3. Prescription drug coverage will be subject to Medical Mutual ACA Advantage formulary. No benefits are payable if your prescription drug order is filled using a non-contracting pharmacy.
Generic Incentive: If member/provider requests a brand, the member pays the brand copay plus the cost difference between brand and generic.

Berkshire Local School District

Benefit Period: January 1, 2025, through December 31, 2026

		SDC Plan #1478 Plan Pays	
		In-Network	Non-Network
Benefits	Benefit Period Deductible (applies to Basic and Major services)	$25/$75	$25/$75
	Benefit Period Maximum (per member)	$1,250	$1,250
	Reimbursement Basis	Network Allowable	Network Allowable
	Preventive Services		
	Oral Exams (two per benefit period)	100%	100%
	Prophylaxis (cleaning — two per benefit period)	100%	100%
	Topical Application of Fluoride (once per benefit period for children under age 19)	100%	100%
	Sealants (once per lifetime per tooth for children under age 15)	100%	100%
	Bitewing X-rays (two per benefit period)	100%	100%
	Full Mouth X-rays or Panoramic Survey (once in three years)	100%	100%
	Periapical X-ray (four per benefit period)	100%	100%
	Enhanced Benefit	100%	100%
	Basic Services		
	Specialty Evaluation (one per benefit period)	80% after deductible	80% after deductible
	Space Maintainers (once per lifetime for children under 19)	80% after deductible	80% after deductible
	Composite or Amalgam Fillings (once per two years per surface)	80% after deductible	80% after deductible
	Minor Restorative Services (once per two years per surface)	80% after deductible	80% after deductible
	Extractions	80% after deductible	80% after deductible
	Endodontics/Pulp Services	80% after deductible	80% after deductible
	Periodontal Services	80% after deductible	80% after deductible
	Minor Emergency Treatment (temporary relief of pain, bleeding or swelling)	80% after deductible	80% after deductible
	Oral Surgery	80% after deductible	80% after deductible
	General Anesthesia or IV Sedation	80% after deductible	80% after deductible
	Major Services		
	Crowns and Onlays (once every five years)	50% after deductible	50% after deductible
	Bridges (pontics and retainer units — one every five years)	50% after deductible	50% after deductible
	Partial and Complete Dentures (one every five years)	50% after deductible	50% after deductible
	Repairs (once a year)	80% after deductible	80% after deductible
	Relines (once in two years)	50% after deductible	50% after deductible
	Implants (once per lifetime per tooth)	50% after deductible	50% after deductible
	Occlusal Guards (once every two years)	50% after deductible	50% after deductible
	Orthodontic Services		
	Orthodontics (limited to members under age 20)	80%	80%
	Orthodontics Lifetime Maximum (per eligible member)	$1,000	$1,000

Out-of-network reimbursement based on the allowable in-network fee schedule.

Any out-of-network service may be subject to a "balance bill" for any amount that the dentist's charge exceeds the allowable amount for an eligible service.

To review the complete list of covered services, limitations and exclusions, refer to SDC's Evidence of Coverage and the Schedule of Benefits associated with the plan number above.

Benefits listed as of 12/2/2024.

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Frequently Asked Questions

Can I choose any dentist?

Yes. Your dental plan lets you choose any licensed dentist for services, but you may pay more for a service if you visit a dentist or specialist who does not participate in the SDC network. By staying in the network, you can pay less out of pocket for your dental care and avoid unexpected out-of-network balance billing, which is when an out-of-network dental provider bills for the difference between their fee for a service and our reimbursement amount.

What is an in-network dentist?

An in-network or participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members.

How do I find an in-network dentist?

SDC offers one of the largest dental networks in the United States. Find a participating dentist or specialist near you with our Find-A-Dentist search tool at SuperiorDental.com.

If my dental office does not recognize the Superior Dental Care name, how can network participation be confirmed?

If a dental office is not familiar with SDC, confirm network participation by referencing "Maximum Care", the name of SDC's national dental network. The Maximum Care logo can be found on the back of your ID card in the claims submission section.

If my dentist is not a participating network provider, how can they join the network?

If your dentist or specialist does not currently participate in SDC's network, you can refer them to us for network recruiting by completing our Dentist Referral Form at SuperiorDental.com/find-a-dentist or calling 1-800-801-4915. You are also encouraged to ask your dentist to consider joining SDC's network.

Is there a waiting period before I can get dental services once I'm enrolled?

No. There are no waiting periods once you enroll in an SDC dental plan. You can use these services as soon as your coverage begins.

What tools and resources are available to me?

SDC makes it easy to manage your dental plan. Our online member portal, Superior Direct Connect, and our SDC mobile app offer convenient access to your ID card, summary of benefits, claim status, Explanation of Benefits (EOBs) and more. We also offer an Interactive Voice Response (IVR) telephone system available 24/7. Simply call 1-800-801-4915 to verify enrollment, check claim status or order new ID cards, or choose to speak to an SDC Member Services representative during business hours (Monday–Friday, 7:30am–5:00pm EST).

Can I find out what my out-of-pocket expenses will be before receiving a service?

Yes. A pre-determination of benefits will tell you what your out-of-pocket expenses are going to be and what your plan will cover for a specific treatment based on information provided by your dentist. You can ask your dentist to request a pre-determination from SDC for any treatment or service before it is performed. A pre-determination is necessary when a proposed treatment plan exceeds $400 or includes periodontal treatment. Once your dentist submits a pre-determination form, it will be reviewed by our dental consultants (who are licensed dentists), estimated benefits will be determined, and a document with this information will be mailed to both you and your dentist. Please note that this benefit verification does not guarantee payment. The amount payable is subject to all the contract limitations effective at the time the services are rendered.

Important Details

This information provides an overview of dental benefits. Once a group policy is issued to your employer, Evidence of Coverage and Schedule of Benefits documents will be available to explain your coverage in detail. All dental plans include certain limitations and exclusions.

Benefits will be determined based on the administrative policies and procedures of SDC in accordance with the Schedule of Benefits.

This document is only a partial listing of benefits. This is not a contract of insurance. To review the complete list of covered services, limitations and exclusions, refer to SDC's Evidence of Coverage and the Schedule of Benefits associated with your plan number.

MEDICAL MUTUAL®

EyeMed

10_25_150 - 12.12.12

Vision Care Services	In-Network Member Cost	Out-of Network Reimbursement[1]
Exam with Dilation as necessary	$10 copay	Up to $30
Contact Lens Fit & Follow-up Standard contact lens fit & follow-up Premium contact lens fit & follow-up	 Up to $40 10% off retail price	 N/A N/A
Frames	$0 co-pay, $150 allowance; 20% off balance over $150	Up to $75
Standard Plastic Lenses Single vision Bifocal Trifocal Lenticular Standard Progressive Lens Premium Progressive Lens[2]	 $25 copay $25 copay $25 copay $25 copay $90 copay Copay based on tier	 Up to $30 Up to $45 Up to $60 Up to $60 Up to $45 Up to $45
Lens Options UV Treatment Tint (solid and gradient) Standard plastic scratch coating Standard Polycarbonate - adults Standard polycarbonate - kids under 19 Standard anti-reflective coating Premium anti-reflective coating Polarized Other add-ons and services	 $15 $15 $0 copay $40 $0 copay $45 Copay based on tier 20% off retail price 20% off retail price	 N/A N/A $8 N/A $20 N/A N/A N/A N/A
Contact Lenses (contact lens allowance includes materials only. Any remaining balance for contact lenses may be used within the same benefit frequency)		
Conventional Disposable Medically necessary	$0 copay, $150 allowance; 15% off balance over $150 $0 copay, $150 allowance $0 copay, paid in full	Up to $120 Up to $120 $210 allowance
Laser Vision Correction LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	
Frequency Examination Lenses or contact lenses Frames Laser Vision Correction	 Once every 12 months Once every 12 months Once per lifetime	

ADDITIONAL DISCOUNTS:

- 40% off complete pair of prescription eyeglasses*
- 20% off non-prescription sunglasses*
- 20% off remaining balance beyond plan coverage*

You're on the INSIGHT network. For a complete list of providers near you, use our Provider Locator on EyeMed.com or call 1.877.226.1115. For LASIK providers, call 1.877.5LASER6

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

These discounts are for in-network providers only

[1]For the period beginning 1/1/2022

[2]Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. All providers are not required to carry all brands at all levels.

No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. See the Provider Locator to find participating providers who offer the discounted rate.

Benefits will be determined based on the certificate of insurance issued by Medical Mutual. Like most insurance plans, this Vision insurance includes certain limitations and exclusions. A complete list of exclusions can be found in the certificate of insurance once the policy is issued.

MEDICAL MUTUAL®

EyeMed

10_25_150 - 12.12.12

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Contact Lenses (contact lens allowance includes materials only. Any remaining balance for contact lenses may be used within the same benefit frequency)		
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