

# HEALTH PLAN COMPARISON CHART

MEDICAL MUTUAL OF OHIO (MMO) PLANS – COSE GROUPS CAN SIMULTANEOUSLY OFFER ANY TWO STANDARD PLANS AND ONE HEALTH SAVINGS ACCOUNT (HSA) OR HEALTH REIMBURSEMENT ARRANGEMENT (HRA) COMPATIBLE PLAN.																
	250/500 **Supermed Plus *Supermed Classic Gold	500/1000 **Supermed Plus *Supermed Classic Gold	750/1500 **Supermed Plus *Supermed Classic Gold	1000/2000 **Supermed Plus *Supermed Classic Gold	SUPERMED PLUS 2080 - 250	SUPERMED PLUS 2080 - 500	SUPERMED PLUS 2080 - 750	SUPERMED PLUS 2080 - 1000	SUPERMED MULTIPLE OPTION 100	SUPERMED MULTIPLE OPTION 90	SUPERMED MULTIPLE OPTION 80	SUPERMED PLUS 1000/3000 HRA	SUPERMED PLUS 2000/6000 HRA	SUPERMED PLUS 3000/9000 HRA	SUPERMED PLUS 1500 (Aggregate Deductible)	SUPERMED PLUS 2000/4000 (Aggregate Deductible)
	(AVAILABLE AS AN HEALTH REIMBURSEMENT ARRANGEMENT.)															
ANNUAL DEDUCTIBLE	Network: \$250 single \$500 family	Network: \$500 single \$1,000 family	Network: \$750 single \$1,500 family	Network: \$1,000 single \$2,000 family	Network: \$250 single \$500 family	Network: \$500 single \$1,000 family	Network: \$750 single \$1,500 family	Network: \$1,000 single \$2,000 family	Network: None Non-Network: \$250 single \$500 family	Network: None Non-Network: \$250 single \$500 family	Network: \$100 single \$200 family Non-Network: \$250 single \$500 family	Network: \$1,000 single \$3,000 family Non-Network: \$2,000 single \$6,000 family	Network: \$2,000 single \$6,000 family Non-Network: \$4,000 single \$12,000 family	Network: \$3,000 single \$9,000 family Non-Network: \$6,000 single \$18,000 family	Network: \$1,500 single \$3,000 Family Non-Network: \$3,000 single \$6,000 family	Network: \$2,000 single \$4,000 family Non-Network: \$2,000 single \$4,000 family
COINSURANCE	Plus: Network: 80% Non-Network: 64% for most services Classic Gold: Network: 90% Non-Network: 80%				Network: 80% Non-network: 60% for most services		Network: 80% Non-network: 60% for most services		Network: 100% Non-Network: 70% for most services	Network: 90% Non-Network: 70% for most services	Network: 80% Non-Network: 60% for most services	Network: 100% Non-Network: 80% for most services			Network: 100% Non-Network: 60%	Network: 100% Non-Network: 80%
OUT-OF-POCKET MAXIMUM (EXCLUDING DEDUCTIBLE)	Plus: Network: \$1,250 single; \$2,500 family Non-Network: \$2,500 single; \$5,000 family Classic Gold: \$1,250 single; \$2,500 family		Plus: Network: \$1,500 single; \$3,000 family Non-Network: \$2,500 single; \$5,000 family Classic Gold: \$1,500 single; \$3,000 family		Network: \$2,000 single \$4,000 family Non-Network: \$4,000 single \$8,000 family	Network: \$2,500 single \$5,000 family Non-Network: \$5,000 single \$10,000 family	Network: \$2,500 single \$5,000 family Non-Network: \$5,000 \$10,000	Network: None Non-Network: \$1,500 single \$3,000 family	Network: \$1,250 single \$2,500 family Non-Network: \$3,000 single \$6,000 family	Network: None Non-Network: \$4,000 single \$12,000 family	Network: None Non-Network: \$8,000 single \$24,000 family	Network: None Non-Network: \$12,000 single \$36,000 family	Network: None Non-Network: \$3,000 single \$6,000 family	Network: None Non-Network: \$1,500 single \$3,000 family		
OFFICE/SPECIALIST OFFICE VISITS	\$15/\$15 copayment then 100%		\$20/\$20 copayment then 100%		\$20/\$20 copayment then 100%		\$20/\$40 copayment then 100%		\$15/\$15 copayment then 100%	\$20/\$20 copayment then 100%	\$20/\$20 copayment then 100%	\$20/\$20 copayment then 100%			100% after deductible	100% after deductible
DIAGNOSTIC SERVICES EXCLUDING MRI'S AND CT SCANS	100%				100%		100%		100%	100%	100%	100%			100% after deductible	100% after deductible
WELL BABY & CHILD CARE	\$15 copayment then 100% up to \$1,000 per benefit period		\$20 copayment then 100% up to \$1,000 per benefit period		\$20 copayment then 100% up to \$1,000 per benefit period		\$20 copayment then 100% up to \$1,000 per benefit period		\$15 copayment then 100%	\$20 copayment then 100%	\$20 copayment then 100%	\$20 copayment then 100% up to \$1,000 per benefit period			100%	100%
INPATIENT HOSPITAL CARE	Plus: 80% after deductible Classic Gold: 90% after deductible				80% after deductible		80% after deductible		100%	90%	80% after deductible	100% after deductible			100% after deductible	100% after deductible
INPATIENT MATERNITY CARE	Plus: 80% after deductible Classic Gold: 90% after deductible				80% after deductible		80% after deductible		100%	90%	80% after deductible	100% after deductible			100% after deductible	100% after deductible
EMERGENCY ROOM COVERAGE	Plus: \$150 copayment then 80% Classic Gold: \$150 copayment then 90%				\$150 copayment then 80%		\$150 copayment then 80%		\$150 copayment then 100%	\$150 copayment then 90%	\$150 copayment then 80%	\$150 copayment then 100%			100% after deductible (Maximum 30 days per benefit period)	100% after deductible (Maximum 30 days per benefit period)
INPATIENT MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT	Plus: 80% after deductible Classic Gold: 90% after deductible (Maximum 30 days per benefit period)				80% after deductible (Maximum 30 days per benefit period)		80% after deductible (Maximum 30 days per benefit period)		100% (Maximum 30 days per benefit period)	90% (Maximum 30 days per benefit period)	80% after deductible (Maximum 30 days per benefit period)	100% after deductible (Maximum 30 days per benefit period)			100% after deductible (Maximum 30 days per benefit period)	100% after deductible (Maximum 30 days per benefit period)
OUTPATIENT MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT	\$15 copayment then 80% after deductible (Maximum 20 visits per benefit period)		\$20 copayment then 80% after deductible (Maximum 20 visits per benefit period)		\$20 copayment then 80% after deductible (Maximum 20 visits per benefit period)		\$40 Copayment then 80% after deductible (Maximum 20 visits per benefit period)		\$15 copayment then 100% (Maximum 20 visits per benefit period)	\$20 copayment then 90% (Maximum 20 visits per benefit period)	\$20 copayment then 80% (Maximum 20 visits per benefit period)	\$20 copayment then 100% after deductible (Maximum 20 visits per benefit period)			100% after deductible (Maximum 20 visits per benefit period)	100% after deductible (Maximum 20 visits per benefit period)
PRESCRIPTION DRUGS (ORAL CONTRA-CEPTIVES & MAIL ORDER INCLUDED)	Several RX options available			RX treated like other medical expenses	Several RX options available		Several RX options available		Several RX options available						RX treated like other medical expenses	RX treated like other medical expenses

NOTE: This comparison chart is a general overview of benefits for COSE-sponsored plans. Specific benefits are listed for services received within the network. This is not a certificate of coverage.

\*You may receive services from any hospital or physician network. Network and non-network deductibles apply to each other.

\*\*You must receive services from a SuperMed hospital and a SuperMed Plus physician to receive maximum benefits.

\*\*\* This plan utilizes the HMO Health Ohio network and requires the selection of a Primary Care Provider.