

	Copay Plans		High Deductible Plans	HSA Plans	Value Plans
	Elite Plans with Office Copay	Premium Plans with Office Copay	Elite Plans without Office Copay	Wellness HSA Plans	Value Plans
Network	SuperMed	SuperMed	SuperMed	SuperMed	SuperMed
Plan Type	PPO	PPO	PPO	PPO	PPO
Deductible	\$500; \$1,000; \$1,500, \$2,500 (2x for Family)	\$500; \$1,000; \$1,500; \$2,500 (2x for Family)	\$2,500; \$5,000; \$10,000 (2x for Family)	\$1,500; \$2,500; \$3,000; \$5,000 (2x for Family)	Individual: \$500; \$1,000; \$1,500 (2x for Family)
Co-insurance	80%	80%	100%	100%	70%
Co-insurance Out-Of-Pocket Maximum	\$2,500 (2x for Family)	\$10,000 (2x for Family)	N/A	N/A	\$500 ded: \$3,500; \$1,000 ded: \$4,000; \$1,500 ded: \$4,500 (2x for Family)
Doctor Visit	Office Visit: \$30 copay, then 100% Specialty Visit: \$40 copay, then 100% Urgent Care: \$50 copay then 100%	Office Visit: \$40 copay, then 100% Specialty Visit: \$50 copay, then 100% Urgent Care: \$75 copay, then 100%	Office Visit: 100% after deductible Urgent Care: 100% after deductible	Office Visit: 100% after deductible Urgent Care: 100% after deductible	Office Visit: 70% after deductible Urgent Care: 70% after deductible
Preventive Services	In accordance with state and federal law ¹	In accordance with state and federal law ¹	In accordance with state and federal law ¹	In accordance with state and federal law ¹	In accordance with state and federal law ¹
Overall Annual Benefit Period Maximum	\$7,500,000	\$7,500,000	\$7,500,000	\$7,500,000	\$7,500,000
Prescription Drugs	\$15/\$30/\$60 Copay Rx	\$15/\$30/\$60 Copay Rx	\$15/\$30/\$60 Copay Rx	100% after deductible	\$15 copay – generic only
Emergency Visit	80% after deductible	80% after deductible	100% after deductible	100% after deductible	70% after deductible
Inpatient Services	80% after deductible	80% after deductible	100% after deductible	100% after deductible	70% after deductible
Outpatient Services (include physical therapy, occupational therapy, speech therapy, cardiac rehab, chiro services)	80% after deductible	80% after deductible	100% after deductible	100% after deductible	70% after deductible
Diagnostic Services (lab, x-ray)	80% after deductible	80% after deductible	100% after deductible	100% after deductible	70% after deductible
Optional Coverage	Maternity, Dental, Vision, Life	Maternity, Dental, Vision, Life	Maternity, Dental, Vision, Life	Dental, Vision, Life	Dental, Vision, Life

- ¹ Preventive services include evidence-based services that have a rating of “A” or “B”, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.
- All benefits listed are based on use of SuperMed network provider.
- Benefit grid is intended to be high level summary of plan offerings. For complete benefit details please refer to your certificate of coverage, or contact your independent insurance broker for additional details.

 MEDICAL MUTUAL OF OHIO®  OHIO FARM BUREAU®	90% Standard Plans	80% Standard Plans	High Deductible Plans	Wellness HSA Plans	Value Plans
Network	SuperMed	SuperMed	SuperMed	SuperMed	SuperMed
Plan Type	PPO	PPO	PPO	PPO	PPO
Deductible	\$750; \$1,500 (2x for Family)	\$750; \$1,500; \$2,500, \$3,500 (2x for Family)	\$2,000; \$4,000; \$7,500 (2x for Family)	\$1,750; \$2,500; \$3,500; \$5,000 (2x for Family)	Individual: \$750; \$1,500; \$2,500 (2x for Family)
Co-insurance	90%	80%	100%	100%	70%
Network Co-insurance Out-Of-Pocket Maximum	\$1,750 (2x for Family)	\$3,000 (2x for Family)	N/A	N/A	\$10,000 (2x for Family)
Doctor Visit	Office Visit: \$35 copay, then 100% Specialty Visit: \$45 copay, then 100% Urgent Care: \$75 copay, then 100%	Office Visit: \$35 copay, then 100% Specialty Visit: \$45 copay, then 100% Urgent Care: \$75 copay, then 100%	Office Visit: 100% after deductible Urgent Care: 100% after deductible	Office Visit: 100% after deductible Urgent Care: 100% after deductible	Office Visit: \$50 copay, then 100% Urgent Care: \$100 copay, then 100%
Preventive Services	In accordance with state and federal law ¹	In accordance with state and federal law ¹	In accordance with state and federal law ¹	In accordance with state and federal law ¹	In accordance with state and federal law ¹
Overall Annual Benefit Period Maximum	\$7,500,000	\$7,500,000	\$7,500,000	\$7,500,000	\$7,500,000
Prescription Drugs	\$15 Generic/\$35 Formulary/50% Non-Formulary	\$15 Generic/\$35 Formulary/50% Non-Formulary	\$15 Generic/\$35 Formulary/50% Non-Formulary	100% after deductible	\$15 copay – generic only
Emergency Visit	90% after deductible	80% after deductible	100% after deductible	100% after deductible	70% after deductible
Inpatient Services	90% after deductible	80% after deductible	100% after deductible	100% after deductible	70% after deductible
Outpatient Services (include physical therapy, occupational therapy, speech therapy, cardiac rehab, chiro services)	90% after deductible	80% after deductible	100% after deductible	100% after deductible	70% after deductible
Diagnostic Services (lab, x-ray)	90% after deductible	80% after deductible	100% after deductible	100% after deductible	70% after deductible
Optional Coverage	Dental, Vision	Dental, Vision	Dental, Vision	Dental, Vision	Dental, Vision

- ¹ Preventive services include evidence-based services that have a rating of “A” or “B”, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.
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