



## SuperMed One — Ohio Farm Bureau Health Plans



BENEFIT SUMMARIES FOR OHIO  
FOR INDIVIDUALS AND FAMILIES UNDER 65



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# OHIO FARM BUREAU 90% STANDARD PLANS

BENEFITS	750/1500	1500/3000
Benefit Period	January 1 through December 31	
Dependent Age Limit	19 Dependent; 23 Student; Removal upon End of Month	
Lifetime Maximum	\$2,500,000	
Benefit Period Deductible – Single/Family	\$750/\$1,500	\$1,500/\$3,000
Non Network Benefit Period Deductible – Single/Family	\$1,500/\$3,000	\$3,000/\$6,000
	PPO NETWORK	NON-PPO NETWORK
Coinsurance	90%	70%
Coinsurance Out-of-Pocket Maximum – (Excluding Deductible) - Single/Family	\$1,250/\$2,500	\$5,000/\$10,000
PHYSICIAN/OFFICE SERVICES		
Office Visit (Illness/Injury)	\$30 copay, then 100%	70% after deductible
Urgent Care Office Visit	\$60 copay, then 100%	\$60 copay, then 100%
Immunizations	90% after deductible	70% after deductible <sup>1</sup>
PREVENTIVE SERVICES		
Routine Physical Exam	100% not subject to deductible	70% after deductible <sup>1</sup>
Routine EyeMed Vision Exam (one per benefit period)	100% not subject to deductible	Not Covered
Oral Exams (one per benefit period)	100% not subject to deductible	100% not subject to deductible
Well Child Care Services to age nine. Well Child Care Exams and Well Child Immunizations are limited to a \$500 maximum per benefit period		
Well Child Exam	100% not subject to deductible	70% after deductible <sup>1</sup>
Well Child Immunizations and Labs	100% not subject to deductible	70% after deductible
Routine Mammogram (One per benefit period)	100% not subject to deductible	70% after deductible
Routine Pap Test (One per benefit period)	100% not subject to deductible	70% after deductible
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period)	100% not subject to deductible	70% after deductible <sup>1</sup>
OUTPATIENT SERVICES		
Allergy Testing and Treatments	90% after deductible	70% after deductible <sup>1</sup>
Diagnostic Services	90% after deductible	70% after deductible
Surgery	90% after deductible	70% after deductible
Physical Therapy (Institutional & Professional – 20 visits per benefit period)	90% after deductible	70% after deductible
Occupational Therapy (Institutional & Professional – 20 visits per benefit period)	90% after deductible	70% after deductible
Speech Therapy (Institutional & Professional – 20 visits per benefit period)	90% after deductible	70% after deductible
Chiropractic Therapy (Professional Only – 12 visits per benefit period)	90% after deductible	70% after deductible
Cardiac Rehabilitation (Institutional – 20 visits per benefit period)	90% after deductible	70% after deductible
Emergency Use of a Hospital Emergency Room	90% after deductible	70% after deductible
Non-Emergency Use of a Hospital Emergency Room	90% after deductible	70% after deductible
INPATIENT FACILITY		
Semi-Private Room and Board	90% after deductible	70% after deductible
Skilled Nursing Facility (\$10,000 maximum per benefit period)	90% after deductible	70% after deductible
ADDITIONAL SERVICES		
Ambulance	90% after deductible	70% after deductible
Durable Medical Equipment	90% after deductible	70% after deductible
Home Healthcare (60 visits per benefit period)	90% after deductible	70% after deductible <sup>1</sup>
Hospice	90% after deductible	70% after deductible <sup>1</sup>
Organ and Tissue Transplants <sup>2</sup>	90% after deductible	70% after deductible
Value Vision	Discount <sup>3</sup>	None
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Mental/Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period and three admits per lifetime)	90% after deductible	50% after deductible <sup>1</sup>
Outpatient Mental/Substance Abuse Visits (20 visits per benefit period)	50% after deductible <sup>1</sup>	50% after deductible <sup>1</sup>
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED		
Prescription Drug Benefit	Generic/Formulary/Non-Formulary:	
Retail copay for 30 day supply	\$15 / \$35 / 50%	
Home Delivery copay for 90 day supply	\$37.50 / \$87.50 / 50%	

Please refer to the back page for important information.

<sup>1</sup> Coinsurance does not apply to out-of-pocket maximums. These services will not be covered at 100% once out-of-pocket maximum is met.

<sup>2</sup> The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual Case Manager (except for corneal transplants.) Failure to contact Care Management prior to the proposed course of treatment (including the evaluation) will result in a \$5,000 penalty. There will be a \$10,000 non-network penalty for failure to use a SuperMed facility or a non designated organ transplant network healthcare professional. This penalty may be waived by the Case Manager if the proper pre-determination procedures are followed.

<sup>3</sup> A separate Value Vision discount program highlight sheet is available. If SuperMed Vision is purchased, Value Vision will be removed from the base benefit.

<sup>4</sup> Drug benefit contains the following:

- Rx Selections<sup>®</sup> Drug List: A list of drugs on the Rx Selections formulary will be used
- Generic Incentive: If the member or physician requests a brand-name drug, and a generic equivalent exists, the member pays the generic co-payment PLUS the difference between the cost of the generic drug and the brand-name drug
- Home Delivery Incentive: When a member chooses to fill a prescription a fourth time at a retail pharmacy within 180 days, the member will pay twice the normal retail co-payment.

## OHIO FARM BUREAU 80% STANDARD PLANS

BENEFITS	750/1500	1500/3000	2500/5000
Benefit Period	January 1 through December 31		
Dependent Age Limit	19 Dependent; 23 Student; Removal upon End of Month		
Lifetime Maximum	\$2,500,000		
Benefit Period Deductible – Single/Family	\$750/\$1,500	\$1,500/\$3,000	\$2,500/\$5,000
Non Network Benefit Period Deductible – Single/Family	\$1,500/\$3,000	\$3,000/\$6,000	\$5,000/\$10,000
	PPO NETWORK	NON-PPO NETWORK	
Coinsurance	80%	50%	
Coinsurance Out-of-Pocket Maximum – (Excluding Deductible) - Single/Family	\$2,500/\$5,000	\$5,000/\$10,000	
PHYSICIAN/OFFICE SERVICES			
Office Visit (Illness/Injury)	\$30 copay, then 100%	50% after deductible	
Urgent Care Office Visit	\$60 copay, then 100%	\$60 copay, then 100%	
Immunizations	80% after deductible	50% after deductible <sup>1</sup>	
PREVENTIVE SERVICES			
Routine Physical Exam	100% not subject to deductible	50% after deductible <sup>1</sup>	
Routine EyeMed Vision Exam (one per benefit period)	100% not subject to deductible	Not Covered	
Oral Exams (one per benefit period)	100% not subject to deductible	100% not subject to deductible	
Well Child Care Services to age nine. Well Child Care Exams and Well Child Immunizations are limited to a \$500 maximum per benefit period			
Well Child Exam	100% not subject to deductible	50% after deductible <sup>1</sup>	
Well Child Immunizations and Labs	100% not subject to deductible	50% after deductible	
Routine Mammogram (One per benefit period)	100% not subject to deductible	50% after deductible	
Routine Pap Test (One per benefit period)	100% not subject to deductible	50% after deductible	
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period)	100% not subject to deductible	50% after deductible <sup>1</sup>	
OUTPATIENT SERVICES			
Allergy Testing and Treatments	80% after deductible	50% after deductible <sup>1</sup>	
Diagnostic Services	80% after deductible	50% after deductible	
Surgery	80% after deductible	50% after deductible	
Physical Therapy (Institutional & Professional – 20 visits per benefit period)	80% after deductible	50% after deductible	
Occupational Therapy (Institutional & Professional – 20 visits per benefit period)	80% after deductible	50% after deductible	
Speech Therapy (Institutional & Professional – 20 visits per benefit period)	80% after deductible	50% after deductible	
Chiropractic Therapy (Professional Only – 12 visits per benefit period)	80% after deductible	50% after deductible	
Cardiac Rehabilitation (Institutional – 20 visits per benefit period)	80% after deductible	50% after deductible	
Emergency Use of a Hospital Emergency Room	80% after deductible	50% after deductible	
Non-Emergency Use of a Hospital Emergency Room	80% after deductible	50% after deductible	
INPATIENT FACILITY			
Semi-Private Room and Board	80% after deductible	50% after deductible	
Skilled Nursing Facility (\$10,000 maximum per benefit period)	80% after deductible	50% after deductible	
ADDITIONAL SERVICES			
Ambulance	80% after deductible	50% after deductible	
Durable Medical Equipment	80% after deductible	50% after deductible	
Home Healthcare (60 visits per benefit period)	80% after deductible	50% after deductible <sup>1</sup>	
Hospice	80% after deductible	50% after deductible <sup>1</sup>	
Organ and Tissue Transplants <sup>2</sup>	80% after deductible	50% after deductible	
Value Vision	Discount <sup>3</sup>	None	
MENTAL HEALTH AND SUBSTANCE ABUSE			
Inpatient Mental/Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period and three admits per lifetime)	80% after deductible	50% after deductible <sup>1</sup>	
Outpatient Mental/Substance Abuse Visits (20 visits per benefit period)	50% after deductible <sup>1</sup>	50% after deductible <sup>1</sup>	
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED			
Prescription Drug Benefit	Generic/Formulary/Non-Formulary:		
Retail copay for 30 day supply	\$15 / \$35 / 50%		
Home Delivery copay for 90 day supply	\$37.50 / \$87.50 / 50%		

Please refer to the back page for important information.

<sup>1</sup> Coinsurance does not apply to out-of-pocket maximums. These services will not be covered at 100% once out-of-pocket maximum is met.

<sup>2</sup> The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual Case Manager (except for corneal transplants.) Failure to contact Care Management prior to the proposed course of treatment (including the evaluation) will result in a \$5,000 penalty. There will be a \$10,000 non-network penalty for failure to use a SuperMed facility or a non-designated organ transplant network healthcare professional. This penalty may be waived by the Case Manager if the proper pre-determination procedures are followed.

<sup>3</sup> A separate Value Vision discount program highlight sheet is available. If SuperMed Vision is purchased, Value Vision will be removed from the base benefit.

<sup>4</sup> Drug benefit contains the following:

- Rx Selections® Drug List: A list of drugs on the Rx Selections formulary will be used

- Generic Incentive: If the member or physician requests a brand-name drug, and a generic equivalent exists, the member pays the generic co-payment PLUS the difference between the cost of the generic drug and the brand-name drug

- Home Delivery Incentive: When a member chooses to fill a prescription a fourth time at a retail pharmacy within 180 days, the member will pay twice the normal retail co-payment.

# OHIO FARM BUREAU HIGH DEDUCTIBLE STANDARD PLANS

BENEFITS	2000/4000	4000/8000
Benefit Period	January 1 through December 31	
Dependent Age Limit	19 Dependent; 23 Student; Removal upon End of Month	
Lifetime Maximum	\$2,500,000	
Benefit Period Deductible – Single/Family	\$2,000/\$4,000	\$4,000/\$8,000
Non Network Benefit Period Deductible – Single/Family	\$4,000/\$8,000	\$8,000/\$16,000
	PPO NETWORK	NON-PPO NETWORK
Coinsurance	100%	50%
Coinsurance Out-of-Pocket Maximum – (Excluding Deductible) - Single/Family	N/A	\$5,000/\$10,000
PHYSICIAN/OFFICE SERVICES		
Office Visit (Illness/Injury)	100% after deductible	50% after deductible
Urgent Care Office Visit	100% after deductible	50% after deductible
Immunizations	100% after deductible	50% after deductible
PREVENTIVE SERVICES		
Routine Physical Exam	100% not subject to deductible	50% after deductible <sup>1</sup>
Routine EyeMed Vision Exam (one per benefit period)	100% not subject to deductible	Not Covered
Oral Exams (one per benefit period)	100% not subject to deductible	100% not subject to deductible
Well Child Care Services to age nine. Well Child Care Exams and Well Child Immunizations are limited to a \$500 maximum per benefit period		
Well Child Exam	100% not subject to deductible	50% after deductible <sup>1</sup>
Well Child Immunizations and Labs	100% not subject to deductible	50% after deductible
Routine Mammogram (One per benefit period)	100% not subject to deductible	50% after deductible
Routine Pap Test (One per benefit period)	100% not subject to deductible	50% after deductible
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period)	100% not subject to deductible	50% after deductible <sup>1</sup>
OUTPATIENT SERVICES		
Allergy Testing and Treatments	100% after deductible	50% after deductible <sup>1</sup>
Diagnostic Services	100% after deductible	50% after deductible
Surgery	100% after deductible	50% after deductible
Physical Therapy (Institutional & Professional – 20 visits per benefit period)	100% after deductible	50% after deductible
Occupational Therapy (Institutional & Professional – 20 visits per benefit period)	100% after deductible	50% after deductible
Speech Therapy (Institutional & Professional – 20 visits per benefit period)	100% after deductible	50% after deductible
Chiropractic Therapy (Professional Only – 12 visits per benefit period)	100% after deductible	50% after deductible
Cardiac Rehabilitation (Institutional – 20 visits per benefit period)	100% after deductible	50% after deductible
Emergency Use of a Hospital Emergency Room	100% after deductible	50% after deductible
Non-Emergency Use of a Hospital Emergency Room	100% after deductible	50% after deductible
INPATIENT FACILITY		
Semi-Private Room and Board	100% after deductible	50% after deductible
Skilled Nursing Facility (\$10,000 maximum per benefit period)	100% after deductible	50% after deductible
ADDITIONAL SERVICES		
Ambulance	100% after deductible	50% after deductible
Durable Medical Equipment	100% after deductible	50% after deductible
Home Healthcare (60 visits per benefit period)	100% after deductible	50% after deductible <sup>1</sup>
Hospice	100% after deductible	50% after deductible <sup>1</sup>
Organ and Tissue Transplants <sup>2</sup>	100% after deductible	50% after deductible
Value Vision	Discount <sup>3</sup>	None
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Mental/Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period and three admits per lifetime)	100% after deductible	50% after deductible <sup>1</sup>
Outpatient Mental/Substance Abuse Visits (20 visits per benefit period)	50% after deductible <sup>1</sup>	50% after deductible <sup>1</sup>
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED		
Prescription Drug Benefit	Generic/Formulary/Non-Formulary:	
Retail copay for 30 day supply	\$15 / \$35 / 50%	
Home Delivery copay for 90 day supply	\$37.50 / \$87.50 / 50%	

Please refer to the back page for important information.

<sup>1</sup> Coinsurance does not apply to out-of-pocket maximums. These services will not be covered at 100% once out-of-pocket maximum is met.

<sup>2</sup> The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual Case Manager (except for corneal transplants.) Failure to contact Care Management prior to the proposed course of treatment (including the evaluation) will result in a \$5,000 penalty. There will be a \$10,000 non-network penalty for failure to use a SuperMed facility or a non designated organ transplant network healthcare professional. This penalty may be waived by the Case Manager if the proper pre-determination procedures are followed.

<sup>3</sup> A separate Value Vision discount program highlight sheet is available. If SuperMed Vision is purchased, Value Vision will be removed from the base benefit.

<sup>4</sup> Drug benefit contains the following:

- Rx Selections<sup>5</sup> Drug List: A list of drugs on the Rx Selections formulary will be used
- Generic Incentive: If the member or physician requests a brand-name drug, and a generic equivalent exists, the member pays the generic co-payment PLUS the difference between the cost of the generic drug and the brand-name drug
- Home Delivery Incentive: When a member chooses to fill a prescription a fourth time at a retail pharmacy within 180 days, the member will pay twice the normal retail co-payment.

# OHIO FARM BUREAU VALUE PLANS

BENEFITS	750/1500	1500/3000	2500/5000
Benefit Period	January 1 through December 31		
Dependent Age Limit	19 Dependent; 23 Student; Removal upon End of Month		
Lifetime Maximum	\$2,000,000		
Benefit Period Deductible – Single/Family	\$750/\$1,500	\$1,500/\$3,000	\$2,500/\$5,000
Non Network Benefit Period Deductible – Single/Family	\$3,000/\$6,000	\$6,000/\$12,000	\$10,000/\$20,000
Coinsurance Out-of-Pocket Maximum – Single/Family	\$10,000/\$20,000	\$10,000/\$20,000	\$10,000/\$20,000
Non Network Coinsurance Out-of-Pocket Maximum – Single/Family	Unlimited	Unlimited	Unlimited
	NETWORK	NON-NETWORK	
Coinsurance	70%	50%	
PHYSICIAN/OFFICE SERVICES			
Office Visit (Illness/Injury)	\$50 copay, then 100%	50% after deductible	
Urgent Care Office Visit <sup>1</sup>	\$100 copay, then 100%	50% after deductible	
Immunizations	70% after deductible	50% after deductible <sup>1</sup>	
PREVENTIVE SERVICES			
Routine Physical Exam	\$50 copay, then 100%		
Routine EyeMed Vision Exam (one per benefit period)	100% not subject to deductible	Not Covered	
Oral Exams (one per benefit period)	100% not subject to deductible	100% not subject to deductible	
Well Child Care Services to age nine. Well Child Care Exams and Well Child Immunizations are limited to a \$500 per child to age 1; thereafter, \$150 per child from birth to age 9	100% not subject to deductible	50% after deductible	
Routine Pap Test (One per benefit period)	100% not subject to deductible	50% after deductible	
Routine Mammogram (One per benefit period)	100% not subject to deductible	50% after deductible	
Routine EKG, Chest X-ray, Comprehensive Metabolic panel, Urinalysis and complete blood count	Not Covered		
OUTPATIENT SERVICES			
Allergy Testing and Treatments	70% after deductible	50% after deductible <sup>1</sup>	
Diagnostic Services	70% after deductible	50% after deductible	
Surgery	70% after deductible	50% after deductible	
Physical Therapy (Institutional & Professional – 10 visits per benefit period)	70% after deductible	50% after deductible	
Occupational Therapy (Institutional & Professional – 10 visits per benefit period)	70% after deductible	50% after deductible	
Speech Therapy (Institutional & Professional – 10 visits per benefit period)	70% after deductible	50% after deductible	
Chiropractic Therapy (Professional Only – 6 visits per benefit period)	70% after deductible	50% after deductible	
Emergency Use of a Hospital Emergency Room	70% after deductible		
Non-Emergency Use of a Hospital Emergency Room	Not Covered		
INPATIENT FACILITY			
Semi-Private Room and Board	70% after deductible	50% after deductible	
Skilled Nursing Facility (\$10,000 maximum per benefit period)	70% after deductible	50% after deductible	
ADDITIONAL SERVICES			
Ambulance Services (\$2,500 maximum per benefit period)	70% after deductible	50% after deductible	
Durable Medical Equipment	50% after deductible	50% after deductible	
Home Healthcare (60 visits per benefit period)	70% after deductible	50% after deductible <sup>1</sup>	
Hospice	70% after deductible	50% after deductible <sup>1</sup>	
Organ and Tissue Transplants <sup>2</sup>	70% after deductible	50% after deductible	
Value Vision	Discount <sup>3</sup>	None	
MENTAL HEALTH AND SUBSTANCE ABUSE			
Inpatient Mental/Substance Abuse Services (10 days per benefit period; Inpatient and Outpatient Substance Abuse Limited to \$550 per benefit period) <sup>4</sup>	70% after deductible	50% after deductible <sup>1</sup>	
Outpatient Mental/Substance Abuse Services (10 days per benefit period; Inpatient and Outpatient Substance Abuse Limited to \$550 per benefit period) <sup>4</sup>	50% after deductible <sup>1</sup>	50% <sup>2</sup> after deductible <sup>1</sup>	
PRESCRIPTION DRUG			
Benefit Period Maximum	\$500		
Retail – 30 Day Supply	\$15 Copay – Generic drugs only <sup>4</sup>		
Home Delivery – 90 Day Supply	\$45 Copay – Generic drugs only		

Please refer to the back page for important information.

<sup>1</sup> Coinsurance does not apply to out-of-pocket maximums. These services will not be covered at 100% once out-of-pocket maximum is met.

<sup>2</sup> The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual Case Manager (except for corneal transplants.) Failure to contact Care Management prior to the proposed course of treatment (including the evaluation) will result in a \$5,000 penalty. There will be a \$10,000 non-network penalty for failure to use a SuperMed facility or a non designated organ transplant network healthcare professional. This penalty may be waived by the Case Manager if the proper pre-determination procedures are followed.

<sup>3</sup> A separate Value Vision discount program highlight sheet is available. If SuperMed Vision is purchased, Value Vision will be removed from the base benefit.

<sup>4</sup> The prescription drug benefit does not cover brand-name prescriptions under any circumstance. This applies even if a brand name drug is medically necessary and a generic substitute is not available. This also applies even when your doctor writes "dispense as written" on your prescription.

## OHIO FARM BUREAU WELLNESS HSA-COMPATIBLE PLANS

BENEFITS	1200/2400	2400/4800
Benefit Period	January 1 through December 31	
Dependent Age Limit	19 Dependent, 23 Student; Removal upon End of Month	
Lifetime Maximum	\$2,500,000	
Network Benefit Period Deductible — Single/Family	\$1,200/\$2,400 <sup>1</sup>	\$2,400/\$4,800
Non-Network Benefit Period Deductible — Single/Family	\$2,400/\$4,800 <sup>1</sup>	\$4,800/\$9,600
	NETWORK	NON-NETWORK
Network Coinsurance — Single/Family	80%	50%
Network Coinsurance Out-of-Pocket Maximum – Single/Family	\$2,000/\$4,000	\$4,000/\$8,000
PHYSICIAN/OFFICE SERVICES		
Office Visit (Illness/Injury)	80% after deductible	50% after deductible
Urgent Care Office Visit	80% after deductible	50% after deductible
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services.)	80% after deductible	50% after deductible
PREVENTIVE SERVICES		
Routine Physical Exam	100% not subject to deductible	50% after deductible
Routine EyeMed Vision Exam (one per benefit period)	100% not subject to deductible	Not Covered
Oral Exams (one per benefit period)	100% not subject to deductible	100% not subject to deductible
Well Child Care Services to age nine. Well Child Exams and Well Child Immunizations are limited to a \$500 maximum per benefit period.		
Office Visit & Immunizations	100% not subject to deductible	50% after deductible
Routine Pap Test (One per benefit period)	100% not subject to deductible	50% after deductible
Routine Mammogram (One per benefit period)	100% not subject to deductible	50% after deductible
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period.)	100% not subject to deductible	50% after deductible
OUTPATIENT SERVICES		
Allergy Testing and Treatments	80% after deductible	50% after deductible
Diagnostic Services	80% after deductible	50% after deductible
Surgery	80% after deductible	50% after deductible
Physical Therapy (Institutional and Professional – 20 visits per benefit period)	80% after deductible	50% after deductible
Occupational Therapy (Institutional and Professional – 20 visits per benefit period)	80% after deductible	50% after deductible
Speech Therapy (Institutional and Professional – 20 visits per benefit period)	80% after deductible	50% after deductible
Chiropractic Therapy (Professional Only – 12 visits per benefit period)	80% after deductible	50% after deductible
Cardiac Rehabilitation (Institutional Only – 20 visits per benefit period)	80% after deductible	50% after deductible
Emergency Use of a Hospital Emergency Room	80% after deductible	80% after deductible
Non-Emergency Use of a Hospital Emergency Room	80% after deductible	50% after deductible
INPATIENT FACILITY		
Semi-Private Room and Board	80% after deductible	50% after deductible
Skilled Nursing Facility (\$10,000 maximum per benefit period)	80% after deductible	50% after deductible
ADDITIONAL SERVICES		
Ambulance (\$2,500 maximum per benefit period)	80% after deductible	50% after deductible
Durable Medical Equipment	80% after deductible	50% after deductible
Home Health Care (60 visits per benefit period)	80% after deductible	50% after deductible
Hospice	80% after deductible	50% after deductible
Organ and Tissue Transplants <sup>2</sup>	80% after deductible	50% after deductible
Value Vision	Discount <sup>3</sup>	None
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Mental/Substance Abuse Services (30 days per benefit period; substance abuse limited to one admission per benefit period and three admits per lifetime)	80% after deductible	50% <sup>4</sup> after deductible
Outpatient Mental/Substance Abuse Services (20 visits per benefit period)	50% after deductible	50% <sup>4</sup> after deductible
PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED		
Retail — 90 Day Supply	80% after deductible	50% after deductible
Home Delivery — 90 Day Supply	80% after deductible	Not Covered

<sup>1</sup> Maximum family deductible. Family deductible must be met before benefits are provided on a family contract.

<sup>2</sup> The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual case manager (except for corneal transplants). Failure to contact Care Management prior to the proposed course of treatment (including the evaluation) will result in a \$5,000 penalty. There will be a \$10,000 non-network penalty for failure to use a SuperMed facility or a non-designated organ transplant network healthcare professional. This penalty may be waived by the Case Manager if the proper pre-determination procedures are followed.

<sup>3</sup> A separate Value Vision discount program highlight sheet is available. If SuperMed Vision is purchased, Value Vision will be removed from the base benefit.

<sup>4</sup> Coinsurance does not apply to out of pocket maximums. These services will not be covered at 100% once out-of-pocket maximum is met.

## OHIO FARM BUREAU WELLNESS HSA-COMPATIBLE PLANS

BENEFITS	1750/3500	2500/5000	3500/7000	5000/10000
Benefit Period	January 1 through December 31			
Dependent Age Limit	19 Dependent, 23 Student; Removal upon End of Month			
Lifetime Maximum	\$2,500,000			
Network Benefit Period Deductible — Single/Family	1,750/3,500 <sup>1</sup>	\$2,500/\$5,000	\$3,500/\$7,000	\$5,000/\$10,000
Non-Network Benefit Period Deductible — Single/Family	1,750/3,500 <sup>1</sup>	\$2,500/\$5,000	\$3,500/\$7,000	\$5,000/\$10,000
	<b>NETWORK</b>		<b>NON-NETWORK</b>	
Network Coinsurance — Single/Family	100%		50%	
Network Coinsurance Out-of-Pocket Maximum – Single/Family	N/A		\$4,000/\$8,000	
<b>PHYSICIAN/OFFICE SERVICES</b>				
Office Visit (Illness/Injury)	100% after deductible		50% after deductible	
Urgent Care Office Visit	100% after deductible		50% after deductible	
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services.)	100% after deductible		50% after deductible	
<b>PREVENTIVE SERVICES</b>				
Routine Physical Exam	100% not subject to deductible		50% after deductible	
Routine EyeMed Vision Exam (one per benefit period)	100% not subject to deductible		Not Covered	
Oral Exams (one per benefit period)	100% not subject to deductible		100% not subject to deductible	
Well Child Care Services to age nine. Well Child Exams and Well Child Immunizations are limited to a \$500 maximum per benefit period.				
Office Visit & Immunizations	100% not subject to deductible		50% after deductible	
Routine Pap Test (One per benefit period)	100% not subject to deductible		50% after deductible	
Routine Mammogram (One per benefit period)	100% not subject to deductible		50% after deductible	
Routine EKG, Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period.)	100% not subject to deductible		50% after deductible	
<b>OUTPATIENT SERVICES</b>				
Allergy Testing and Treatments	100% after deductible		50% after deductible	
Diagnostic Services	100% after deductible		50% after deductible	
Surgery	100% after deductible		50% after deductible	
Physical Therapy (Institutional and Professional – 20 visits per benefit period)	100% after deductible		50% after deductible	
Occupational Therapy (Institutional and Professional – 20 visits per benefit period)	100% after deductible		50% after deductible	
Speech Therapy (Institutional and Professional – 20 visits per benefit period)	100% after deductible		50% after deductible	
Chiropractic Therapy (Professional Only – 12 visits per benefit period)	100% after deductible		50% after deductible	
Cardiac Rehabilitation (Institutional Only – 20 visits per benefit period)	100% after deductible		50% after deductible	
Emergency Use of a Hospital Emergency Room	100% after deductible		100% after deductible	
Non-Emergency Use of a Hospital Emergency Room	100% after deductible		50% after deductible	
<b>INPATIENT FACILITY</b>				
Semi-Private Room and Board	100% after deductible		50% after deductible	
Skilled Nursing Facility (\$10,000 maximum per benefit period)	100% after deductible		50% after deductible	
<b>ADDITIONAL SERVICES</b>				
Ambulance (\$2,500 maximum per benefit period)	100% after deductible		50% after deductible	
Durable Medical Equipment	100% after deductible		50% after deductible	
Home Health Care (60 visits per benefit period)	100% after deductible		50% after deductible	
Hospice	100% after deductible		50% after deductible	
Organ and Tissue Transplants <sup>1</sup>	100% after deductible		50% after deductible	
Value Vision	Discount <sup>2</sup>		None	
<b>MENTAL HEALTH AND SUBSTANCE ABUSE</b>				
Inpatient Mental/Substance Abuse Services (30 days per benefit period; substance abuse limited to one admission per benefit period and three admits per lifetime)	100% after deductible		50% <sup>4</sup> after deductible	
Outpatient Mental/Substance Abuse Services (20 visits per benefit period)	50% after deductible		50% <sup>4</sup> after deductible	
<b>PRESCRIPTION DRUG - ORAL CONTRACEPTIVES INCLUDED</b>				
Retail — 90 Day Supply	100% after deductible		50% after deductible	
Home Delivery — 90 Day Supply	100% after deductible		Not Covered	

<sup>1</sup> Maximum family deductible. Family deductible must be met before benefits are provided on a family contract.

<sup>2</sup> The proposed course of treatment for organ/tissue transplants must be pre-determined and approved by a Medical Mutual case manager (except for corneal transplants). Failure to contact Care Management prior to the proposed course of treatment (including the evaluation) will result in a \$5,000 penalty. There will be a \$10,000 non-network penalty for failure to use a SuperMed facility or a non designated organ transplant network healthcare professional. This penalty may be waived by the Case Manager if the proper pre-determination procedures are followed.

<sup>3</sup> A separate Value Vision discount program highlight sheet is available. If SuperMed Vision is purchased, Value Vision will be removed from the base benefit.

<sup>4</sup> Coinsurance does not apply to out of pocket maximums. These services will not be covered at 100% once out-of-pocket maximum is met.

# OHIO FARM BUREAU VISION BENEFITS

BENEFITS	NETWORK	NON-NETWORK <sup>1</sup>
Dependent Age Limit	19 Dependent, 23 Student; Removal upon end of month	

## PROFESSIONAL SERVICES (ONE EVERY 12 MONTHS)

Spectacle exam	\$15 copayment	\$15 maximum
Contact lens exam	\$15 copayment + any amount over spectacle exam	\$15 maximum

## MATERIALS

Frame (One every 12 months)	\$0 copayment (Up to \$100) 20% off amount (Over \$100)	\$30 maximum
Lenses (Uncoated plastic. One pair every 12 months)		
Single Vision	\$15 copayment	\$10 maximum
Bifocal	\$15 copayment	\$20 maximum
Trifocal	\$15 copayment	\$30 maximum
Lenticular	\$15 copayment	\$40 maximum
Contact lenses (instead of lenses and frames one pair per calendar year)		
Cosmetic	\$15 copayment (Up to \$100)	\$40 maximum
Medically necessary	\$15 copayment (Up to \$200)	\$75 maximum
Disposable	\$15 copayment (Up to \$100)	\$40 maximum

## LISTED BELOW ARE ADDITIONAL WAYS TO SAVE ON LENS OPTIONS AND CONTACT LENSES.

If EyeMed Vision Care provider is used, members are entitled to a discount in addition to the lens copayments listed above. The discount applies to items whether or not they are covered as part of a vision plan. The available discounted lens options are listed below.

Lens Options	Discounted Price (in addition to the \$15 lens copayment)
Anti-reflective coating	\$45
Glass	20% off retail price
Photochromic	20% off retail price
Polycarbonate	\$40
Progressive (no-line bifocal)	\$65
Scratch-resistant coating	\$15
Solid tint or Gradient tint	\$15
Ultraviolet coating	\$15

- Contact Lenses**
1. Visit a participating EyeMed Vision Care location and save 15% on non-disposable or medically necessary contact lenses.
  2. Use the mail-order Vision One Contact Lens Replacement Program and apply discounts when ordering contacts by mail.

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, verbally or in writing, to change the benefits listed here. The contract or certificate will contain the complete listing of covered services.

**NOTES:**  
The discount schedule for lens options and contact lenses listed above is subject to change by EyeMed Vision Care.

<sup>1</sup> The non-network maximum is the amount a member receives for covered vision services received from a non-network healthcare professional.



## OHIO FARM BUREAU DENTAL® BENEFITS

BENEFITS	NETWORK	NON-NETWORK
Benefit Period	January 1 through December 31	
Dependent Age Limit	19 Dependent, 23 Student; Removal upon end of month	
Annual Maximum (per member)	\$1,000 per benefit period	
Benefit Period Deductible	\$50 per individual	\$100 per individual
<b>PREVENTIVE SERVICES</b>		
Oral Exams – 2 per benefit period	100%	80%
Bite Wing X-rays – 2 per benefit period	100%	80%
Prophylaxis (cleaning) – 2 per benefit period	100%	80%
Fluoride Treatment – 1 treatment per benefit period, limited to age 19	100%	80%
Space Maintainers- limited to age 19	100%	80%
Emergency Palliative Treatment – includes emergency oral exam	100%	80%
<b>ESSENTIAL SERVICES</b>		
Fillings	80% after deductible	60% after deductible

### BENEFIT EXCLUSIONS AND LIMITATIONS

SuperMed One does not provide benefits for services, supplies or charges for the following:

- Diagnostic X-Rays
- Minor Restorative Services
- Endodontics/Pulp Services
- Apicoectomy
- Periodontal Services
- Repairs, Relines & Adjustments of Prosthetics
- Simple Extractions
- Impactions
- Alveoplasty
- Minor Oral Surgery Services
- General Anesthesia
- Gold Foil Restoration
- Inlays, Onlays
- Crowns
- Bridgework (Pontics & Abutments)
- Partial and Complete Dentures
- Orthodontic Diagnostic Services
- Minor Treatment for Tooth Guidance
- Minor Treatment for Harmful Habits
- Interceptive Orthodontic Treatment
- Comprehensive Orthodontic Treatment

To locate a DenteMax dentist, you can contact Medical Mutual at 866/DENTAL1 (866/336-8251); visit the Medical Mutual Web site at MedMutual.com; contact DenteMax at 800/752-1547; or visit the DenteMax Web site at DenteMax.com.

#### NOTE:

Benefit will be determined based on Medical Mutual of Ohio's medical and administrative policies and procedures. This document is only a partial listing of dental benefits. This is not a contract of insurance. Your certificate of insurance provides a complete listing of covered services.

## BENEFIT EXCLUSIONS AND LIMITATIONS

Coverage is not provided for services and supplies:

- Incurred before the policy effective date.
- Incurred after the policy termination date.
- For experimental or investigation of drugs, devices, medical treatments or procedures.
- That are not medically necessary.
- To the extent governmental units or their agencies provide benefits.
- For a condition that occurs as a result of any act of war.
- Received from a member of your immediate family.
- For which payment was made or would have been made under Medicare Parts A or B if benefits were claimed.
- Received in a military facility for a military service-related condition.
- For surgery and other services primarily to improve appearance or to treat a mental or emotional condition through a change in body form.
- For treatment of a condition related to an autistic disease of childhood, learning disabilities, hyperkinetic syndromes, behavioral problems or mental retardation, except as specified.
- For arch supports and other foot care or foot support devices used only to improve comfort or appearance which include but are not limited to, care of flatfeet, subluxations, corns, bunions, calluses and toenails.
- For treatment, by methods such as prescription drugs, dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss or for weight loss through surgery. This includes complications resulting from weight loss surgery or such other methods as may be recognized by the National Institutes of Health.
- For marital counseling.
- For the medical treatment of sexual problems not caused by a biological disease.
- For transsexual surgery or any treatment leading to, or in connection with transsexual surgery.
- For birth control devices which include, but are limited to, IUD's and diaphragms.
- For reverse sterilization.
- For artificial insemination or in vitro fertilization.
- For hypnosis and acupuncture.
- For fraudulent or misrepresented claims.

Consult your Certificate of Coverage for a complete listing of benefits and exclusions.

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### NOTES:

Deductible expenses incurred for services by a network doctor or hospital will only apply to the network deductible. Deductible expenses incurred for services by a non-network doctor or hospital will only apply to the non-network deductible.

Coinsurance expenses incurred for services by a PPO network doctor or hospital will only apply to the PPO network coinsurance out-of-pocket. Coinsurance expenses incurred for services by a Non-PPO network doctor or hospital will only apply to the Non-PPO network coinsurance out-of-pocket.

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, verbally 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 healthcare professional's billed charges or Medical Mutual's negotiated rate with the healthcare professional.

**Medical Mutual of Ohio**  
2060 East Ninth Street  
Cleveland, OH 44115-1355