SuperMed One – Ohio Farm Bureau

MEDICAL MUTUAL OF OHIO®

Z7264 R9/10

Ohio Farm Bureau
90% Standard Plans

Base Plan	750	1500
Network 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
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$1,750/$3,500	$1,750/$3,500
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$5,000/$10,000	$5,000/$10,000
Office Visit (OV) Copay	$35	
Specialty visit (SV) Copay	$45	
Urgent Care (UC) Copay	$75	
Coinsurance Network/Non-Network	90% / 70%	
Overall Annual Benefit Period Maximum	$7,500,000	

Benefits	PPO Network	Non-PPO Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	28; Removal upon End of the Month	
Physician/Office Services		
Office Visit (Illness/Injury)	$35 copay, then 100%	70% after deductible
Specialty Office Visit	$45 copay, then 100%	70% after deductible
Urgent Care Office Visit	$75 copay, then 100%	$75 copay, then 100%
Standard Immunizations	90% after deductible	70% after deductible[1]
Preventive Services		
Preventive Services, in accordance with state and federal law[2]	100%	70% after deductible[1]
Routine Physical Exam	100%	70% after deductible[1]
Routine EyeMed Vision Exam (one per benefit period)	100%	Not Covered
Oral Exams (one per benefit period)	100%	100%
Prophylaxis (cleaning) – (one per benefit period)	100%	100%
Well Child Care Services to age nine. Well Child Care Exams Well Child Care Immunizations & Labs	100%	70% after deductible[1] 70% after deductible
Routine Mammogram (one per benefit period)	100%	70% after deductible
Routine Pap Test (one per benefit period)	100%	70% after deductible
Routine EKG, Chest X-ray, Comprehensive Metabolic Panel, Urinalysis and Complete Blood Count (one each per benefit period)	100%	70% after deductible
Routine PSA, Cholesterol, Colon Cancer Screening Tests, Bone Density Tests and Endoscopic Services	100%	70% after deductible
Outpatient Services		
Allergy Testing and Treatments	90% after deductible	70% after deductible[1]
Physical Therapy (20 visits per benefit period)	90% after deductible	70% after deductible
Occupational Therapy (20 visits per benefit period)	90% after deductible	70% after deductible
Speech Therapy (20 visits per benefit period)	90% after deductible	70% after deductible
Chiropractic Services (12 visits per benefit period)	90% after deductible	70% after deductible
Cardiac Rehabilitation (20 visits per benefit period)	90% after deductible	70% after deductible

continued on page 2

Ohio Farm Bureau 90% Standard Plans

Benefits	PPO Network	Non-PPO Network
Outpatient Services (cont'd)		
Emergency Use of an Emergency Room	90% after deductible	
Non-Emergency Use of an Emergency Room	90% after deductible	70% after deductible
Surgical Services	90% after deductible	70% after deductible
Diagnostic Services	90% after deductible	70% after deductible
Diagnostic Endoscopic Services	100%	70% after deductible
Inpatient Services		
Semi-Private Room and Board	90% after deductible	70% after deductible
Skilled Nursing Facility (100 days per benefit period)	90% after deductible	70% after deductible
Additional Services		
Ambulance	80% after deductible	
Durable Medical Equipment	90% after deductible	70% after deductible
Home Health Care (60 days per benefit period)	90% after deductible	70% after deductible[1]
Hospice	90% after deductible	70% after deductible[1]
Organ and Tissue Transplants	90% after deductible	70% after deductible
Value Vision	Discount[2]	None
Mental Health & Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period, three admissions per lifetime)	90% after deductible	70% after deductible[1]
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	50% after deductible[1]	50% after deductible[1]
Prescription Drug Coverage– Oral Contraceptives Included[3]		
Retail – 30 Day Supply	$15 Generic / $35 Formulary / 50% Non-Formulary	
Home Delivery – 90 Day Supply	$37.50 Generic / $87.50 Formulary / 50% Non-Formulary	

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 and coinsurance expenses incurred for services by a network provider will only apply to the network deductible and coinsurance out-of-pocket. Deductible and coinsurance expenses incurred for services by a non-network provider will only apply to the non-network deductible and coinsurance out-of-pocket.

The coinsurance for non-contracting institutional providers will be the same coinsurance percentage as the non-network provider. However, you may be subject to balance billing by the non-contracting provider.

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 the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

1 Coinsurance does not apply to coinsurance out-of-pocket maximums. These services will not be covered at 100% once Coinsurance out-of-pocket maximums are met.

2 Preventive services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.

3 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 copayment 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 copayment.

Ohio Farm Bureau
80% Standard Plans

Base Plan	750	1500	2500	3500
Network Benefit Period Deductible Single/Family	$750/$1,500	$1,500/$3,000	$2,500/$5,000	$3,500/$7,000
Non-Network Benefit Period Deductible Single/Family	$1,500/$3,000	$3,000/$6,000	$5,000/$10,000	$7,000/$14,000
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$3,000/$6,000	$3,000/$6,000	$3,000/$6,000	$3,000/$6,000
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$5,000/$10,000	$5,000/$10,000	$5,000/$10,000	$5,000/$10,000
Office Visit (OV) Copay	$35			
Specialty Visit (SP) Copay	$45			
Urgent Care (UC) Copay	$75			
Coinsurance Network/Non-Network	80% / 50%			
Overall Annual Benefit Period Maximum	$7,500,000			

Benefits	PPO Network	Non-PPO Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	28; Removal upon End of the Month	
Physician/Office Services		
Office Visit (Illness/Injury)	$35 copay, then 100%	50% after deductible
Specialty Office Visit	$45 copay, then 100%	50% after deductible
Urgent Care Office Visit	$75 copay, then 100%	$75 copay, then 100%
Standard Immunizations	80% after deductible	50% after deductible[1]
Preventive Services		
Preventive Services, in accordance with state and federal law[2]	100%	50% after deductible[1]
Routine Physical Exam	100%	50% after deductible[1]
Routine EyeMed Vision Exam (one per benefit period)	100%	Not Covered
Oral Exams (one per benefit period)	100%	100%
Prophylaxis (cleaning) – (one per benefit period)	100%	100%
Well Child Care Services to age nine. Well Child Care Exams Well Child Care Immunizations & Labs	100%	50% after deductible[1] 50% after deductible
Routine Mammogram (one per benefit period)	100%	50% after deductible
Routine Pap Test (one per benefit period)	100%	50% after deductible
Routine EKG, Chest X-ray, Comprehensive Metabolic Panel, Urinalysis and Complete Blood Count (one each per benefit period)	100%	50% after deductible
Routine PSA, Cholesterol, Colon Cancer Screening Tests, Bone Density Tests and Endoscopic Services	100%	50% after deductible
Outpatient Services		
Allergy Testing and Treatments	80% after deductible	50% after deductible[1]
Physical Therapy (20 visits per benefit period)	80% after deductible	50% after deductible
Occupational Therapy (20 visits per benefit period)	80% after deductible	50% after deductible
Speech Therapy (20 visits per benefit period)	80% after deductible	50% after deductible
Chiropractic Services (12 visits per benefit period)	80% after deductible	50% after deductible
Cardiac Rehabilitation (20 visits per benefit period)	80% after deductible	50% after deductible
Emergency Use of an Emergency Room	80% after deductible	
Non-Emergency Use of an Emergency Room	80% after deductible	50% after deductible
Surgical Services	80% after deductible	50% after deductible
Diagnostic Services	80% after deductible	50% after deductible
Diagnostic Endoscopic Services	100%	50% after deductible

continued on page 4

Ohio Farm Bureau
80% Standard Plans

Benefits	PPO Network	Non-PPO Network
Inpatient Services		
Semi-Private Room and Board	80% after deductible	50% after deductible
Skilled Nursing Facility (100 days per benefit period)	80% after deductible	50% after deductible
Additional Services		
Ambulance	80% after deductible	
Durable Medical Equipment	80% after deductible	50% after deductible
Home Health Care (60 days per benefit period)	80% after deductible	50% after deductible[1]
Hospice	80% after deductible	50% after deductible[1]
Organ and Tissue Transplants	80% after deductible	50% after deductible
Mental Health & Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period, three admissions per lifetime)	80% after deductible	50% after deductible[1]
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	50% after deductible[1]	50% after deductible[1]
Prescription Drug Coverage– Oral Contraceptives Included[3]		
Retail – 30 Day Supply	$15 Generic / $35 Formulary / 50% Non-Formulary	
Home Delivery – 90 Day Supply	$37.50 Generic / $87.50 Formulary / 50% Non-Formulary	

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Deductible and coinsurance expenses incurred for services by a network provider will only apply to the network deductible and coinsurance out-of-pocket. Deductible and coinsurance expenses incurred for services by a non-network provider will only apply to the non-network deductible and coinsurance out-of-pocket.

The coinsurance for non-contracting institutional providers will be the same coinsurance percentage as the non-network provider. However, you may be subject to balance billing by the non-contracting provider.

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 the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

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1 Coinsurance does not apply to coinsurance out-of-pocket maximums. These services will not be covered at 100% once Coinsurance out-of-pocket maximums are met.

2 Preventive services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.

3 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 copayment 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 copayment.

Ohio Farm Bureau High Deductible Standard Plans

Base Plan	2000	4000	7500
Network Benefit Period Deductible Single/Family	$2,000/$4,000	$4,000/$8,000	$7,500/$15,000
Non-Network Benefit Period Deductible Single/Family	$4,000/$8,000	$8,000/$16,000	$15,000/$30,000
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	N/A	N/A	N/A
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$5,000/$10,000	$5,000/$10,000	$5,000/$10,000
Coinsurance Network/Non-Network	100% / 50%		
Overall Annual Benefit Period Maximum	$7,500,000		

Benefits	PPO Network	Non-PPO Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	28; Removal upon End of the Month	
Physician/Office Services		
Office Visit (Illness/Injury)	100% after deductible	50% after deductible
Urgent Care Office Visit	100% after deductible	50% after deductible
Standard Immunizations	100% after deductible	50% after deductible[1]
Preventive Services		
Preventive Services, in accordance with state and federal law[2]	100%	50% after deductible[1]
Routine Physical Exam	100%	50% after deductible[1]
Routine EyeMed Vision Exam (one per benefit period)	100%	Not Covered
Oral Exams (one per benefit period)	100%	100% not subject to deductible
Prophylaxis (cleaning) – (one per benefit period)	100%	100% not subject to deductible
Well Child Care Services to age nine. Well Child Care Exams Well Child Care Immunizations & Labs	 100% 100%	 50% after deductible[1] 50% after deductible
Routine Mammogram (one per benefit period)	100%	50% after deductible
Routine Pap Test (one per benefit period)	100%	50% after deductible
Routine PSA, Cholesterol, Colon Cancer Screening Tests, Bone Density Tests and Endoscopic Services	100%	50% after deductible
Routine EKG, Chest X-ray, Comprehensive Metabolic Panel, Urinalysis and Complete Blood Count (one each per benefit period)	100%	50% after deductible
Outpatient Services		
Allergy Testing and Treatments	100% after deductible	50% after deductible[1]
Physical Therapy (20 visits per benefit period)	100% after deductible	50% after deductible
Occupational Therapy (20 visits per benefit period)	100% after deductible	50% after deductible
Speech Therapy (20 visits per benefit period)	100% after deductible	50% after deductible
Chiropractic Services (12 visits per benefit period)	100% after deductible	50% after deductible
Cardiac Rehabilitation (20 visits per benefit period)	100% after deductible	50% after deductible
Emergency Use of an Emergency Room	100% after deductible	
Non-Emergency Use of an Emergency Room	100% after deductible	50% after deductible
Surgical Services	100% after deductible	50% after deductible
Diagnostic Services	100% after deductible	50% after deductible
Diagnostic Endoscopic Services	100%	50% after deductible

continued on page 6

Ohio Farm Bureau
High Deductible Standard Plans

Benefits	PPO Network	Non-PPO Network
Inpatient Services		
Semi-Private Room and Board	100% after deductible	50% after deductible
Skilled Nursing Facility (100 days per benefit period)	100% after deductible	50% after deductible
Additional Services		
Ambulance	100% after deductible	
Durable Medical Equipment	100% after deductible	50% after deductible
Home Health Care (60 days per benefit period)	100% after deductible	50% after deductible[1]
Hospice	100% after deductible	50% after deductible[1]
Organ and Tissue Transplants	100% after deductible	50% after deductible
Mental Health & Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period, three admissions per lifetime)	100% after deductible	50% after deductible[1]
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	50% after deductible[1]	50% after deductible[1]
Prescription Drug Coverage – Oral Contraceptives Included[3]		
Retail – 30 Day Supply	$15 Generic / $35 Formulary / 50% Non-Formulary	
Home Delivery – 90 Day Supply	$37.50 Generic / $87.50 Formulary / 50% Non-Formulary	

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

The coinsurance for non-contracting institutional providers will be the same coinsurance percentage as the non-network provider. However, you may be subject to balance billing by the non-contracting provider.

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 the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

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[1] Coinsurance does not apply to coinsurance out-of-pocket maximums. These services will not be covered at 100% once Coinsurance out-of-pocket maximums are met.

[2] Preventive services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.

[3] 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 copayment 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 copayment.

Ohio Farm Bureau Wellness HSA Plans

Base Plan	1750	2500	3500	5000
Network Benefit Period Deductible Single/Family	$1,750/$3,500[1]	$2,500/$5,000	$3,500/$7,000	$5,000/$10,000
Non-Network Benefit Period Deductible Single/Family	$1,750/$3,500[1]	$2,500/$5,000	$3,500/$7,000	$5,000/$10,000
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	N/A	N/A	N/A	N/A
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$3,500/$7,000[2]	$5,000/$10,000	$7,000/$14,000	$10,000/$20,000
Coinsurance Network/Non-Network	100% / 50%			
Overall Annual Benefit Period Maximum	$7,500,000			

Benefits	PPO Network	Non-PPO Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	28; Removal upon End of the Month	
Physician/Office Services		
Office Visit (Illness/Injury)	100% after deductible	50% after deductible
Urgent Care Office Visit	100% after deductible	50% after deductible
Standard Immunizations	100% after deductible	50% after deductible
Preventive Services		
Preventive Services, in accordance with state and federal law[4]	100%	50% after deductible
Routine Physical Exam	100%	50% after deductible
Routine EyeMed Vision Exam (one per benefit period)	100%	Not Covered
Oral Exams (one per benefit period)	100%	100%
Prophylaxis (cleaning) – (one per benefit period)	100%	100%
Well Child Care Services to age nine. Well Child Care Exams, Immunizations & Labs	100%	50% after deductible
Routine Mammogram (one per benefit period)	100%	50% after deductible
Routine Pap Test (one per benefit period)	100%	50% after deductible
Routine PSA, Cholesterol, Colon Cancer Screening Tests, Bone Density Tests and Endoscopic Services	100%	50% after deductible
Routine EKG, Chest X-ray, Comprehensive Metabolic Panel, Urinalysis and Complete Blood Count (one each per benefit period)	100%	50% after deductible
Outpatient Services		
Allergy Testing and Treatments	100% after deductible	50% after deductible
Physical Therapy (20 visits per benefit period)	100% after deductible	50% after deductible
Occupational Therapy (20 visits per benefit period)	100% after deductible	50% after deductible
Speech Therapy (20 visits per benefit period)	100% after deductible	50% after deductible
Chiropractic Services (12 visits per benefit period)	100% after deductible	50% after deductible
Cardiac Rehabilitation (20 visits per benefit period)	100% after deductible	50% after deductible
Emergency Use of an Emergency Room	100% after deductible	
Non-Emergency Use of an Emergency Room	100% after deductible	50% after deductible
Surgical Services	100% after deductible	50% after deductible
Diagnostic Services	100% after deductible	50% after deductible
Diagnostic Endoscopic Services	100%	50% after deductible

continued on page 8

Ohio Farm Bureau
Wellness HSA Plans

Benefits	PPO Network	Non-PPO Network
Inpatient Services		
Semi-Private Room and Board	100% after deductible	50% after deductible
Skilled Nursing Facility (100 days 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 Health Care (60 days per benefit period)	100% after deductible	50% after deductible
Hospice	100% after deductible	50% after deductible
Organ and Tissue Transplants	100% after deductible	50% after deductible
Mental Health & Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (30 days per benefit period; Substance Abuse limited to one admission per benefit period, three admissions per lifetime)	100% after deductible	50% after deductible[3]
Outpatient Mental Health and Substance Abuse Services (20 visits per benefit period)	100% after deductible	50% after deductible[3]
Prescription Drug Coverage– Oral Contraceptives Included (Failure to present an ID card may result in increased cost.)		
Retail – 90 Day Supply Home Delivery – 90 Day Supply	100% after deductible	

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

The coinsurance for non-contracting institutional providers will be the same coinsurance percentage as the non-network provider. However, you may be subject to balance billing by the non-contracting provider.

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 the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

1 Maximum family deductible. Family deductible must be met before benefits are provided on a family contract. The single deductible applies to single contracts.
2 Maximum family coinsurance out-of-pocket. Family coinsurance out-of-pocket must be met before all benefits are paid at 100% on a family contract. The single coinsurance out-of-pocket applies to single contracts.
3 Coinsurance does not apply to coinsurance out-of-pocket maximums. These services will not be covered at 100% once Coinsurance out-of-pocket maximums are met.
4 Preventive services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.

Ohio Farm Bureau Value Plans

Base Plan	750	1500	2500
Network 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
Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	$10,000/$20,000	$10,000/$20,000	$10,000/$20,000
Non-Network Coinsurance Out-of-Pocket Maximum (Excluding Deductible) Single/Family	Unlimited	Unlimited	Unlimited
Coinsurance Network/Non-Network	70% / 50%		
Office Visit Copay	$50		
Urgent Care Copay	$100		
Overall Annual Benefit Period Maximum	$7,500,000		

Benefits	PPO Network	Non-PPO Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	28; Removal upon End of the Month	
Physician/Office Services		
Office Visit (Illness/Injury)	$50 copay, then 100%	50% after deductible
Urgent Care Office Visit	$100 copay, then 100%	50% after deductible
Standard Immunizations	70% after deductible	50% after deductible[1]
Preventive Services		
Preventive Services, in accordance with state and federal law[2]	100%	50% after deductible[1]
Routine Physical Exam	100%	50% after deductible
Routine EyedMed Vision Exam (one per benefit period)	100%	Not Covered
Oral Exams (one per benefit period)	100%	100%
Prophylaxis (cleaning) – (one per benefit period)	100%	100%
Well Child Care Services to age nine. Well Child Care Exams Immunizations & Labs	100%	50% after deductible
Routine Mammogram (one per benefit period)	100%	50% after deductible
Routine Pap Test (one per benefit period)	100%	50% after deductible
Routine EKG, Chest X-ray, Comprehensive Metabolic Panel, Urinalysis and Complete Blood Count	100%	50% after deductible
Outpatient Services		
Allergy Testing and Treatments	70% after deductible	50% after deductible[1]
Physical Therapy (10 visits per benefit period)	70% after deductible	50% after deductible
Occupational Therapy (10 visits per benefit period)	70% after deductible	50% after deductible
Speech Therapy (10 visits per benefit period)	70% after deductible	50% after deductible
Chiropractic Services (6 visits per benefit period)	70% after deductible	50% after deductible
Cardiac Rehabilitation	70% after deductible	50% after deductible
Emergency Use of an Emergency Room	70% after deductible	
Non-Emergency Use of an Emergency Room	NOT COVERED	
Surgical Services	70% after deductible	50% after deductible
Diagnostic Services	70% after deductible	50% after deductible
Inpatient Services		
Semi-Private Room and Board	$250 copay per confinement, then 70% after deductible	50% after deductible
Skilled Nursing Facility (100 days per benefit period)	70% after deductible	50% after deductible

continued on page 10

Ohio Farm Bureau Value Plans

Benefits	PPO Network	Non-PPO Network
Additional Services		
Ambulance	80% after deductible	
Durable Medical Equipment	50% after deductible	50% after deductible
Home Health Care (60 days per benefit period)	70% after deductible	50% after deductible[1]
Hospice	70% after deductible	50% after deductible[1]
Organ and Tissue Transplants	70% after deductible	50% after deductible
Mental Health & Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (10 days per benefit period)	70% after deductible	50% after deductible[1]
Outpatient Mental Health and Substance Abuse Services (10 visits per benefit period)	50% after deductible[1]	50% after deductible[1]
Prescription Drug Coverage		
Retail – 30 Day Supply	$15 copay – Generic drug only[3]	
Home Delivery – 90 Day Supply	$45 copay – Generic drug only[3]	

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Deductible and coinsurance expenses incurred for services by a network provider will only apply to the network deductible and coinsurance out-of-pocket. Deductible and coinsurance expenses incurred for services by a non-network provider will only apply to the non-network deductible and coinsurance out-of-pocket.

The coinsurance for non-contracting institutional providers will be the same coinsurance percentage as the non-network provider. However, you may be subject to balance billing by the non-contracting provider.

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 the case manager prior to the proposed course of treatment (including the evaluation) will result in a significant monetary penalty. Refer to your certificate for details.

[1]Coinsurance does not apply to coinsurance out-of-pocket maximums. These services will not be covered at 100% once Coinsurance out-of-pocket maximums are met.
[2]Preventive services include evidence-based services that have a rating of "A" or "B" in the United States Preventive Services Task Force, routine immunizations and other screenings, as provided for in the Patient Protection and Affordable Care Act.
[3]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 Vision
EyeMed Access Network

Services	Network	Non-Network[1]
Dependent Age Limit	28; 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
Frame (One every 12 months)	$0 copayment (Up to $100. 20% off anything more than $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 (In lieu of lenses and frames. One pair every 12 months)		
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 through the SuperMed Vision program.

Lens options: If an 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
Progressive (no-line bifocal)	$65
Polycarbonate	$40
Scratch-resistant coating	$15
Ultraviolet coating	$15

Lens options	*Discounted price
Anti-reflective coating	$45
Solid tint or Gradient tint	$15
Photochromic	20% off retail price
Glass	20% off retail price

* Discounted price is in addition to the $15 copayment listed above. Discounts available through EyeMed Access providers only.

Contact lenses: Listed below are two convenient ways to obtain 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.

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

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[1] The non-network maximum is the amount a member receives for covered vision services received from a non-network provider.

Ohio Farm Bureau
Dental Benefits

Benefits	Network	Non-Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit	28; Removal End of Month	
Annual Maximum (per member)	$1,000 per benefit period	
Benefit Period Deductible	$50 per individual	$100 per individual
Preventive Services		
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%
Essential Services		
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

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.

	Ohio Farm Bureau Basic Life Insurance and AD&D Highlights	

Benefits	
Life and AD&D Insurance	
	As a participant in the Medical Mutual of Ohio Health plan sponsored by the Ohio Farm Bureau, you are provided Basic Life and AD&D Insurance in an amount equal to $5,000. Life insurance pays your beneficiary (please see below) a benefit if you die while you are covered by the policy. Accidental Death and Dismemberment insurance (AD&D) pays your beneficiary (please see below) a death benefit if you die due to a covered accident while you are insured. It also pays you a benefit for certain accidental injuries. This highlight sheet is an overview of your Basic Life and AD&D Insurance. Once a policy is issued, a certificate of insurance will be available to explain your coverage in detail.
What is the difference between the two policies?	
	AD&D is insurance that pays an additional benefit if you are seriously injured or die due to a covered accident. Basic life insurance pays a benefit if you die for any reason except those excluded in the Certificate of Insurance.
AD&D Coverage	
	You may receive benefits due to certain injuries or death from an accident. The covered injuries or death can occur up to 365 days after that accident. The insurance pays: • 100% of the amount of coverage purchased in the event of accidental loss of life, two limbs, the sight of both eyes, one limb and the sight of one eye, or speech and hearing. • One-half (50%) for accidental loss of one limb, sight of one eye, or speech or hearing. • One-quarter (25%) for accidental loss of thumb and index finger of the same hand. Your total benefit for all losses due to the same accident will not be more than 100% of the amount of coverage purchased. The certificate of insurance includes definitions, a complete list of covered losses and other enhancements and benefits.
Beneficiary	
	Your beneficiary is the person (or persons) or legal entity (entities) who receives a benefit payment if you die while you are insured.

As is standard with most Insurance, this Basic Life and AD&D insurance includes certain limitations and exclusions:

- Basic Life and AD&D insurance coverage will terminate when the certificate holder attains age 65.
- AD&D insurance does not cover specific losses. A complete list of exclusions can be found in your benefit booklet.

Note: This document is only a partial listing of benefits. This is not a contract of insurance. The contract or certificate will contain the complete listing of covered benefits.

continued on page 14

Benefit Exclusions and Limitations

SuperMed One 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.

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.