HEALTH benefits PLAN
OHIO FARM BUREAU

5,000 / 80%
Illustrative Summary of Benefits
PPO Plan

SuperMed Plus

Benefits	Network	Non Network
Benefit Period	January 1st through December 31st	
Dependent Age Limit / Older Age Child	26 - Removal upon End of the Month	
Deductible (Single / Family)	$5,000 / $10,000	$10,000 / $20,000
Maximum Out-of-Pocket (Single / Family)[1]	$6,600 / $13,200	$13,200 / $26,400
Coinsurance (member cost)	20%	40%
Physician/Office Services		
Physician Office Visit	$25 copay, then 100%	coinsurance after deductible
Specialist Office Visit	$25 copay, then 100%	coinsurance after deductible
Urgent Care Office Visit	$50 copay, then 100%	coinsurance after deductible
Emergency Services		
Emergency Use of an Emergency Room	$250 copay, then 100%	
Emergency Services (expenses other than Emergency Room)	network coinsurance after deductible	
Non-Emergency Use of an Emergency Room	Not Covered	
Routine/Preventive Services[2]		
Health Care Reform Benefits	100%	coinsurance after deductible
Health Care Reform Benefits for Women	100%	coinsurance after deductible
All Immunizations	coinsurance after deductible, unless the service is covered under Health Care Reform Preventive Benefits	coinsurance after deductible
Routine Physical Exam (age 21 and over)	100%	coinsurance after deductible
Routine Mammogram (one per benefit period)	100%	coinsurance after deductible
Routine Pap Test (one per benefit period)	100%	coinsurance after deductible
Routine Lab, Medical Tests, and X-rays	coinsurance after deductible, unless the service is covered under Health Care Reform Preventive Benefits	coinsurance after deductible
Routine Endoscopic Services	coinsurance after deductible, unless the service is covered under Health Care Reform Preventive Benefits	coinsurance after deductible
Well Child Care		
Well Child Care Exams, Immunizations and Labs (to age 21)	100%	coinsurance after deductible
Hearing Exams	100%	coinsurance after deductible
Vision Exams	100%	coinsurance after deductible
Lenses (to age 19; 1 pair per benefit period)	coinsurance after deductible	coinsurance after deductible
Frames (to age 19; 1 pair per benefit period)	coinsurance after deductible	coinsurance after deductible
Contacts (in lieu of frames - to age 19; 1 pair per benefit period)	coinsurance after deductible	coinsurance after deductible
Outpatient Services		
Allergy Testing and Treatments	coinsurance after deductible	coinsurance after deductible
Physical & Occupational Therapies (40 visits per benefit period/combined)	coinsurance after deductible	coinsurance after deductible
Speech Therapy (20 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Chiropractic Services (12 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Cardiac Rehabilitation (36 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Surgical Services	coinsurance after deductible	coinsurance after deductible
Diagnostic Lab, Medical Tests, and X-rays	coinsurance after deductible	coinsurance after deductible
Diagnostic Imaging	coinsurance after deductible	coinsurance after deductible
Diagnostic Endoscopic Services	coinsurance after deductible	coinsurance after deductible
Inpatient Services		
Institutional Services	coinsurance after deductible	coinsurance after deductible
Maternity	coinsurance after deductible	coinsurance after deductible
Skilled Nursing Facility (90 days per benefit period)	coinsurance after deductible	coinsurance after deductible

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Benefits	Network	Non Network
Additional Services		
Ambulance	coinsurance after deductible	coinsurance after deductible
Autism Spectrum Disorders (benefit limits apply - refer to Certificate of Coverage)	coinsurance after deductible	coinsurance after deductible
Diabetic Education and Training	coinsurance after deductible, unless the service is covered under Health Care Reform Preventive Benefits	coinsurance after deductible
Durable Medical Equipment	coinsurance after deductible	coinsurance after deductible
DME - Wigs (1 per benefit period, following cancer treatment)	coinsurance after deductible	coinsurance after deductible
Home Health Care (100 visits per benefit period)	coinsurance after deductible	coinsurance after deductible
Hospice	coinsurance after deductible	coinsurance after deductible
Organ and Tissue Transplants	coinsurance after deductible	coinsurance after deductible
Organ Transplant Services (includes travel, meals, lodging and transportation)	coinsurance after deductible	coinsurance after deductible
Private Duty Nursing (90 days per benefit period)	coinsurance after deductible	coinsurance after deductible
Sterilization	coinsurance after deductible	coinsurance after deductible
Mental Health & Substance Abuse - Federal Mental Health Parity		
Inpatient Mental Health and Substance Abuse Services	Benefits paid are based on corresponding medical benefits	
Outpatient Mental Health and Substance Abuse Services		
Prescription Drug Benefits		
Network Pharmacy / Retail (30 day supply)	$15 generic / $30 formulary / $60 non-formulary / 50% specialty	
Network Pharmacy / Retail (30 day supply) Fourth Fill in 180 days	On the fourth fill within 180 days member will pay double the applicable copay or coinsurance.	
Home Delivery/Contracted Provider (90 day supply) (Specialty drugs limited to 30 day supply)	$45 generic / $90 formulary / $180 non-formulary / 50% specialty	
Generic Incentive Applies	If member or provider requests a brand-name drug when a generic equivalent exists, the member pays the generic copay PLUS the difference between the cost of the generic and brand-name drug.	

[1]Network level Out-of-Pocket includes deductible, coinsurance and flat dollar copayments.

[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.

Deductible expenses incurred for services by a PPO Network provider will only apply to the PPO Network deductible. Deductible expenses incurred for services by a Non PPO Network provider will only apply to the Non PPO Network deductible.

Coinsurance expenses incurred for services by a PPO Network provider will only apply to the PPO Network coinsurance out-of-pocket limits. Coinsurance expenses incurred for services by a Non PPO Network provider will only apply to the Non PPO Network coinsurance out-of-pocket limits.

The coinsurance for non-contracting institutional providers will be the same coinsurance percentage as the Non PPO 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.

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.