

# Southern Farm Bureau *HEALTH CARE*

*A Group Health Care Insurance Program To Help Optimize Your Health Care Dollars  
For Members of the Texas Farm Bureau*



Underwritten By:



**Southern Farm Bureau Life Insurance Company**

P.O. Box 78 • Jackson, MS 39205 • (800) 999-8932 \* [www.sfbli.com](http://www.sfbli.com)

Policy Form GMR-FACE-G-00419

## General Information

### Eligibility

An eligible Member is an active dues-paying member of the Texas Farm Bureau who resides in Texas and has reached his or her 18<sup>th</sup> birthday but has not reached his or her 65<sup>th</sup> birthday. Eligible dependents include a lawful spouse of an eligible Member and unmarried dependent children to age 25. Unmarried children include grandchildren who are dependent on the member for Federal income tax purposes at the time of application.

### Underwriting Requirements

Proof of insurability is a condition of issue for members and eligible dependents. The insurance Plan offers a Preferred Underwriting Classification with significant premium savings if you meet certain requirements. (Tobacco use of any kind will automatically eliminate you from Preferred consideration.) Certificates may be issued with exclusions for some existing medical conditions.

### Effective Date and Beginning of Coverage

The effective date of a Member's coverage and that of his or her eligible dependents will be the first day of the month following company approval of the evidence of insurability of the Member and dependents, provided each person is performing the normal activities of a person in good health of like age on that date.

If an eligible person is not performing the normal activities of a person in good health of like age on that date, coverage will become effective on the first of the month coincident with meeting such requirements.

### Termination of Member Coverage

A Member's coverage terminates on the last day of the month in which the earliest of the following occurs:

1. The Member ceases to be eligible;
2. The premium due date if the premium remains unpaid at the end of the premium grace period;
3. The date the group policy is terminated by Southern Farm Bureau Life Insurance Company or the group policyholder.

### Termination of Dependent Coverage

Termination of Dependent insurance will occur on the earliest of:

1. The date Dependent insurance benefits are discontinued under the policy; or
2. The date the Dependent ceases to be eligible for Dependent insurance; i.e., the spouse is no longer the lawful married spouse of the member or the child marries or attains age 25; or
3. The premium due date if the premium remains unpaid at the end of the premium grace period; or
4. The date that the Farm Bureau member's insurance terminates; or
5. The date the spouse or child become insured members.

### Continuation of Coverage

If coverage terminates, a covered person may be eligible to continue coverage on a premium paying basis for up to 6 months in accordance with Texas law. Complete details are provided in the certificate of insurance.

## **Premium Rates**

This program has rates for males, females, and each child. Southern Farm Bureau reserves the right to change rates on any premium due date and any date on which benefits are changed. However, a member's rate may change only if they are changed for all others in the same class of insureds under this group plan. For example, a class of insureds is a group of people with the same issue age and gender. Your agent will assist in calculating the appropriate rate for your selected benefits and geographic location. Renewal rates will be dependent on the age, sex, geographical area, and claim experience of the covered persons under each Certificate, as well as the experience of the program as a whole and other factors. Premiums may be paid monthly by convenient bank draft or quarterly by direct billing.

## **Contestability**

After your coverage has been in force for two years it will become incontestable except for fraud, or for non-payment of premiums.

## **Pre-Existing Conditions Limitations**

Covered charges incurred for pre-existing conditions are not payable unless incurred after the end of a continuous period of 12 consecutive months commencing on or after the effective date of the Covered Person.

A pre-existing condition is any condition whether physical or mental, regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received by a Covered Person during the 6 month period ending on the enrollment date of the Covered Person under this plan.

## **Coordination of Benefits**

If other insurance is in force, benefits may be limited so that combined health benefits will not exceed 100% of allowable charges.

## **Utilization Review**

*Southern Farm Bureau Health Care* includes the special services of a utilization review company. This is an organization that specializes in medical care coordination through review of proposed surgical and hospital care.

The review includes Hospital Pre-Admission Certification, Extended Stay Review, Home Health Care Certification, transportation by air ambulance, treatment for sleep apnea, and Second Surgical Opinion when required. When inpatient care is recommended, the Pre-Admission Certification process certifies a length of stay. The utilization review company will make recommendations when it is found that the same level of treatment can be safely administered in a more cost-effective setting, which may help conserve your overall maximum benefit.

For a scheduled Inpatient Hospital Confinement, Extended Stay Review, and Home Health Plan:

When a non-network provider recommends an admission for non-emergency elective procedures, the patient must call the utilization review company seven (7) days prior to the inpatient admission or the beginning of a treatment program.

If a confinement is arranged through a network provider, the provider will initiate utilization review.

For an Urgent or Emergency (Immediate) Admission:

The utilization review company must be contacted within 48 hours of the admission or the second business day following a weekend or holiday admission or as soon as reasonably possible.

## Quality Care Is Maintained

While these techniques are effective cost controls, the use of these services will not affect the quality of care. The patient and physician will make the ultimate decision about appropriate medical treatment.

Utilization Review does not guarantee benefits. Benefit payment is still subject to all plan provisions and limitations, including pre-existing conditions limitations, premium payment, and valid enrollment. Penalties for Utilization Review Non-Compliance are for each non-compliance admission. Should all or part of the confinement not be certified as medically necessary, no benefits will be payable for the period of time that was not approved.

Failure to comply with pre-admission certification procedures for a scheduled inpatient hospital confinement, extended stay review, and home health care plan may result in a penalty or denial of benefits.

## The Penalties for Non-Compliance for Hospital Inpatient Stays are as Follows

<b>Plan A</b>	\$1,000 and \$3,000 deductible: Coinsurance reduced to 60%.
<b>Plan B</b>	\$1,000 deductible: \$1,000 penalty per hospital admission. \$3,000 and \$5,000 deductible: \$1,500 penalty per hospital admission.
<b>Plan C</b>	\$1,000 deductible: \$1,000 penalty per hospital admission. \$3,000 and \$5,000 deductible: \$1,500 penalty per hospital admission.
<b>Plan D</b>	All deductibles: \$500 penalty per hospital admission.

## Preferred Provider Organization Network

*Southern Farm Bureau Health Care* utilizes preferred provider organizations (PPO's) to secure quality health care from selected providers and hospitals at a reduced cost. An 800 number is available to determine if your provider is a member of the network, or to obtain information about the PPO Network. See the Outline of Coverages to determine how the use of an in-network provider affects your coinsurance. By using these providers, you will conserve valuable benefits and help hold down your out-of-pocket cost, saving you money.

## Major Medical Group Insurance Outline of Coverages

Choice of Plans	Plan A	
	In Network (80%-20%)	Out of Network * (60%-40%)
<b>Coinsurance:</b>		
Overall Maximum per insured while covered	\$2,000,000	
Deductible Options (per Calendar Year)	\$1,000 or \$3,000	
Maximum Family Deductible (per Calendar Year)	Three	
Annual Out-Of Pocket Maximum**	\$2,000 Individual \$6,000 Family	\$4,000 Individual \$12,000 Family
Hospital Admission Deductible (per Calendar Year)	\$0	\$500
Childhood Immunizations through age 5 (deductible waived)	100%	100%
Required Second Surgical Opinion (deductible waived)	100%	100%
Emergency Care	80%	80%
Hospice Care Maximum Benefit (up to \$10,000) (deductible waived for out patient care)	80%	60%
Home Health Care <i>120 visits per calendar year in lieu of hospital confinement; following three days of prior hospital confinement</i>	80%	60%
Spinal Manipulation <i>25 visits per year up to \$1,000 per calendar year</i>	80%	60%
Skilled Nursing Care (for qualified Confinements)	80%	60%
Mental and Nervous Disorders <i>Maximum inpatient days per calendar year – 45 days / Maximum outpatient visits per calendar year – 60 visits</i>	80%	60%
Transplant Coverage <i>One time maximum benefit of \$500,000 per insured if recipient or \$50,000 per insured if donor</i>	80%	60%
Occupational Coverage - Coverage for work related injury or sickness is available only if selected and approved at the time the enrollment form is completed	80%	60%
Hospital Services for radiology, pathology and anesthesiology when services are performed in a:		
PPO Provider Hospital		80%
Non PPO Provider Hospital by a PPO Provider Doctor		80%
Non PPO Provider Hospital by a non PPO Provider Doctor		60%
In Patient Prescription Drugs and Durable Medical Equipment of a medical or surgical nature used solely for treating an injury or sickness		80%
All other Covered Expenses	80%	60%
Outpatient Prescription Retail Drug Program \$100 calendar year drug deductible per person applies Drug copays do not count toward the annual out of pocket maximum or the plan deductible		75% - Generic 50% - Brand
Outpatient Mail Order Drug Program 90 day supply, \$100 calendar year drug deductible per person applies		75% - Generic 50% - Brand
Outpatient Prescription Drug Maximum Per Calendar Year (for all out patient prescription drugs per person)		\$2,500
* <b>If Insured lives more that 50 miles from a network provider or if a network provider cannot provide the necessary services – In-Network benefits will apply.</b>		
** <b>Does not include deductibles, penalties, amounts paid by the insured under the prescription drug benefit, benefits payable for mental disorders or pregnancy, certain doctor’s services and any amounts not paid because the plan maximum benefit has been paid.</b>		

## Major Medical Group Insurance Outline of Coverages

Choice of Plans	Plan B (Co-Pay Plan)	
	In Network (60%-40%)	Out of Network *(50%-50%)
<b>Coinsurance:</b>		
Overall Maximum per insured while covered	\$2,000,000	
Deductible Options (per Calendar Year)	\$1,000 or \$3,000 or \$5,000	
Maximum Family Deductible (per Calendar Year)	Three	
Annual Out-Of Pocket Maximum**	\$5,000 Individual \$15,000 Family	\$6,250 Individual \$18,750 Family
Hospital Admission Deductible (per Calendar Year)	\$0	\$500
Office Visit Co-Pay (5 office visits per calendar year per person) In-Network only	\$25	N/A
Childhood Immunizations through age 5 (deductible waived)	100%	100%
Required Second Surgical Opinion (deductible waived)	100%	100%
Emergency Care	60%	60%
Hospice Care Maximum Benefit (up to \$10,000) (deductible waived for out patient care)	60%	50%
Home Health Care (120 visits per calendar year in lieu of hospital confinement; following three days of prior hospital confinement)	60%	50%
Spinal Manipulation 25 visits per year up to \$1,000 per calendar year	60%	50%
Skilled Nursing Care (for qualified Confinements)	60%	50%
Mental and Nervous Disorders <i>Maximum inpatient days per calendar year – 45 days / Maximum outpatient visits per calendar year – 60 visits</i>	60%	50%
Transplant Coverage <i>One time maximum benefit of \$500,000 per insured if recipient or \$50,000 per insured if donor</i>	60%	50%
Occupational Coverage - Coverage for work related injury or sickness is available only if selected and approved at the time the enrollment form is completed	60%	50%
Hospital Services for radiology, pathology and anesthesiology when services are performed in a:		
PPO Provider Hospital		60%
Non PPO Provider Hospital by a PPO Provider Doctor		60%
Non PPO Provider Hospital by a non PPO Provider Doctor		50%
In Patient Prescription Drugs and Durable Medical Equipment of a medical or surgical nature used solely for treating an injury or sickness		60%
All other Covered Expenses	60%	50%
Outpatient Prescription Retail Drug Program \$100 calendar year drug deductible per person applies Drug copays do not count toward the annual out of pocket maximum or the plan deductible		50% - Generic 50% - Brand
Outpatient Mail Order Drug Program 90 day supply, \$100 calendar year drug deductible per person applies		50% - Generic 50% - Brand
Outpatient Prescription Drug Maximum Per Calendar Year (for all out patient prescription drugs per person)		\$2,500
* If Insured lives more that 50 miles from a network provider or if a network provider cannot provide the necessary services – In-Network benefits will apply.		
** Does not include deductibles, penalties, copay amounts paid by the insured under the prescription drug benefit, benefits payable for mental disorders or pregnancy, certain doctor's services and any amounts not paid because the plan maximum benefit has been paid.		

## Major Medical Group Insurance Outline of Coverages

Choice of Plans	Plan C	
	In Network (60%-40%)	Out of Network *(50%-50%)
<b>Coinsurance:</b>		
Overall Maximum per insured while covered	\$2,000,000	
Deductible Options (per Calendar Year)	\$1,000 or \$3,000 or \$5,000	
Maximum Family Deductible (per Calendar Year)	Three	
Annual Out-Of Pocket Maximum**	\$5,000 Individual \$15,000 Family	\$6,250 Individual \$18,750 Family
Hospital Admission Deductible (per Calendar Year)	\$0	\$500
Childhood Immunizations through age 5 (deductible waived)	100%	100%
Required Second Surgical Opinion (deductible waived)	100%	100%
Emergency Care	60%	60%
Hospice Care Maximum Benefit (up to \$10,000) (deductible waived for out patient care)	60%	50%
Home Health Care <i>120 visits per calendar year in lieu of hospital confinement; following three days of prior hospital confinement</i>	60%	50%
Spinal Manipulation <i>25 visits per year up to \$1,000 per calendar year</i>	60%	50%
Skilled Nursing Care (for qualified Confinements)	60%	50%
Mental and Nervous Disorders <i>Maximum inpatient days per calendar year – 45 days / Maximum outpatient visits per calendar year – 60 visits</i>	60%	50%
Transplant Coverage <i>One time maximum benefit of \$500,000 per insured if recipient or \$50,000 per insured if donor</i>	60%	50%
Occupational Coverage - Coverage for work related injury or sickness is available only if selected and approved at the time the enrollment form is completed	60%	50%
Hospital Services for radiology, pathology and anesthesiology when services are performed in a:		
PPO Provider Hospital		60%
Non PPO Provider Hospital by a PPO Provider Doctor		60%
Non PPO Provider Hospital by a non PPO Provider Doctor		50%
In Patient Prescription Drugs and Durable Medical Equipment of a medical or surgical nature used solely for treating an injury or sickness		60%
All other Covered Expenses	60%	50%
Outpatient Prescription Retail Drug Program \$100 calendar year drug deductible per person applies Drug copays do not count toward the annual out of pocket maximum or the plan deductible		50% - Generic 50% - Brand
Outpatient Mail Order Drug Program 90 day supply, \$100 calendar year drug deductible per person applies		50% - Generic 50% - Brand
Outpatient Prescription Drug Maximum Per Calendar Year (for all out patient prescription drugs per person)		\$2,500
* If Insured lives more that 50 miles from a network provider or if a network provider cannot provide the necessary services – In-Network benefits will apply.		
** Does not include deductibles, penalties, amounts paid by the insured under the prescription drug benefit, benefits payable for mental disorders or pregnancy, certain doctor's services and any amounts not paid because the plan maximum benefit has been paid.		

## Major Medical Group Insurance Outline of Coverages

Choice of Plans	Plan D			
	Option I & II		Option III*	
Coinsurance:	In Network (100%)	Out of Network **(80%-20%)	In Network (80%-20%)	Out of Network **(60%-40%)
Overall Maximum per insured while covered	\$2,000,000		\$2,000,000	
Deductible Options:	<b>Option I</b> \$2,500 Individual \$5,000 Family	<b>Option II</b> \$5,000 Individual \$10,000 Family	<b>Option III</b> \$3,050 Individual \$6,150 Family	
Maximum Family Deductible (per Calendar Year)	One		One	
Annual In Network Out-Of Pocket Maximum (Includes deductibles and penalties)	\$2,500 Individual \$5,000 Family	\$5,000 Individual \$10,000 Family	\$5,950 Individual \$11,900 Family	
Annual Out of Network Out-Of Pocket Maximum (Includes deductibles and penalties)	\$3,300 Individual \$6,050 Family	\$7,500 Individual \$15,000 Family	\$9,000 Individual \$18,050 Family	
Childhood Immunizations through age 5 (deductible waived)	100%	100%	100%	100%
Required Second Surgical Opinion (deductible applies)	100%	100%	100%	100%
Emergency Care	100%	100%	80%	80%
Hospice Care Maximum (\$10,000 maximum benefit) (deductible applies)	100%	80%	80%	60%
Home Health Care	100%	80%	80%	60%
	<i>120 visits per calendar year in lieu of hospital confinement; following three days of prior hospital confinement</i>			
Spinal Manipulation (25 visits per year)	100%	80%	80%	60%
Skilled Nursing Care (for qualified Confinements)	100%	80%	80%	60%
Mental and Nervous Disorders	100%	80%	80%	60%
	<i>Maximum inpatient days per calendar year – 45 days Maximum outpatient visits per calendar year – 60 visits</i>			
Transplant Coverage	100%	80%	80%	60%
	<i>One time maximum benefit of \$500,000 per insured if recipient or \$50,000 per insured if donor</i>			
* The deductible will automatically reflect an amount equal to the inflation adjusted deductible determined by the Internal Revenue Service. The amount of covered expenses to be incurred for 100% payment will change in direct proportion to the deductible.				
** If Insured lives more than 50 miles from a network provider or if a network provider cannot provide the necessary services—In-Network benefits will apply.				

## Major Medical Group Insurance Outline of Coverages

Choice of Plans	Plan D			
	Option I & II		Option III*	
Coinsurance:	In Network (100%)	Out of Network **(80%-20%)	In Network (80%-20%)	Out of Network **(60%-40%)
Occupational Coverage	100%	80%	80%	60%
<i>Coverage for work-related injury or sickness is available only if selected and approved when the enrollment form is completed</i>				
Hospital Services for radiology, pathology and anesthesiology when services are performed in a:				
PPO Provider Hospital		100%		80%
Non PPO Provider Hospital by a PPO Provider Doctor		100%		80%
Non PPO Provider Hospital by a non PPO Provider Doctor		80%		60%
In Patient Prescription Drugs and Durable Medical Equipment of a medical or surgical nature used solely for treating an injury or sickness	100%	80%	80%	60%
All other covered Expenses	100%	80%	80%	60%
<p><b>Outpatient Prescription Retail Drug Program and Mail Order Drug Program</b></p> <p>Outpatient Prescription Drug Maximum Per Calendar Year (for all out patient prescription drugs per person)      \$5,000</p> <p>Includes participation in a national prescription benefit management program that provides an identification card which enables a member to receive a discount when purchasing prescription drugs at a participating pharmacy or through a participating mail order program (90 day supply) for Plan D participants. Covered prescription drug costs count toward the annual out of pocket maximum and the plan deductible.</p>				

## Covered Charges

Covered charges are those for the following services and supplies that are medically necessary for the treatment of an injury or sickness and which are incurred while coverage is in effect. These charges are subject to the policy's Exclusions provisions. The covered expense is subject to usual and prevailing criteria.

### Hospital Care

Hospital care covers medical services and supplies furnished by a Hospital. Room and Board is covered at the average semi-private rate for the hospital. Covered charges for an Intensive Care Unit will not exceed three times the comparable covered Room and Board charges.

### Skilled Nursing Facility Care

Skilled Nursing Facility care covers the Room and Board and nursing care furnished by a Skilled Nursing Facility up to the Facility's regular daily semi-private rate (if confinement starts within fourteen days after discharge from a hospital confinement of at least three days for the illness causing hospital confinement and does not primarily involve routine custodial care).

### Hospice Benefit

Hospice Care Services and Supplies are payable up to a benefit maximum of \$10,000. However, for benefits to be provided the attending physician must:

- Diagnose the Covered Person's condition as being terminal;
- Determine that the person is not expected to live more than six months; and
- Place the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies provided on an inpatient basis shall be payable to the same extent as such charges for any Sickness. Covered Hospice Care Services and Supplies that are provided on an outpatient basis are not subject to any Deductible\* and are payable at the Coinsurance Percentage of the Plan selected and up to the maximum amount shown above.

\*Deductible is not waived for Plan D

### Home Health Care Services and Supplies

Certain Home Health Care services and supplies are provided under the policy provided that they are:

- For care and treatment of an injury or sickness following a Hospital Confinement of at least three days where continued hospital confinement would have otherwise been required;
- Provided under a formal Home Health Care plan supervised by a physician; and
- Certified under the Utilization Review provisions.

Benefit payments for nursing, home health aide and therapy services are limited to 120 visits per Calendar year.

### Physician Care

Physician Care covers the medical treatment and surgical procedures performed by a physician who is not:

- Living with the covered person; or
- A member of the covered person's immediate family including parent, spouse, brother, sister, natural, step, adopted or foster child, grandparent or in-law.

## **Other Covered Expenses, Supplies and Services - Complete details including the amount of coverage, requirements and restrictions are included in the Certificate of Insurance.**

- Anesthetic; oxygen; blood and blood derivatives that are not donated or replaced.
- Diagnostic x-rays and laboratory studies.
- Rental of medically necessary durable medical or surgical equipment to be used only for therapeutic care.
- Local professional ground ambulance service only if the service is to or from a local hospital. Utilization Review approval is required for air ambulance.
- Surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations.
- Leg, arm, back and neck braces if the brace is required because of an injury or sickness that occurred while covered under this program.
- Artificial leg, arm or eye required to replace a lost natural body part provided the loss occurred while covered under this program.
- Physical therapy by a licensed therapist.
- Occupational therapy by a licensed therapist.
- Speech therapy by a licensed speech therapist to restore speech loss or to correct speech impairment that is due to: a birth defect, but only for therapy given after corrective surgery; an injury; or sickness that is other than a mental or learning disorder.
- Vision Therapy administered by a licensed orthoptist or optometrist for treatment within three months before or after surgery to correct an injury or muscle imbalance in the eye.
- Mammography and Pap Smear. A charge for one routine mammographic and pap smear examination, including the office visit charge, during a calendar year.
- Diagnostic and/or surgical treatment of the temporomandibular (jaw or craniomandibular) joint.
- Childhood immunizations for dependent children from birth through the date the child is six years old, but only if the charge is for immunization against diphtheria, haemophilus influenza type B, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, and varicella, and any other immunization required by law.
- An annual physical examination for the detection of prostate cancer for each covered male and a prostate-specific antigen test.
- Foot care expenses but only if charge is for (a) an open cutting operation of metatarsalgia or bunion (b) partial or complete removal of nail root (c) medical care of the feet except as described under "No Benefits are Payable" and (d) other treatment of the feet if it is not a cutting, removal or other treatment of a corn, callus or toenail unless such treatment is needed because of diabetes or other similar disease.
- Child Health Supervision services provided to a child from birth to age 24 months.
- Medically necessary and appropriate care, equipment and supplies in the treatment of diabetes.
- Contact or frame-type lenses for the eye and examination for them if lenses are: (a) required to correct damage caused by an ocular injury that occurs or an intraocular surgery that is performed while the person is covered under this plan; and (b) obtained no later than six months from the date of that injury or surgery.
- Hearing aids and exams for their fitting shall be considered a covered charge if the hearing aid is (a) required to correct damage directly caused by an injury that occurs while covered under this plan and (b) obtained within four months of the date of this injury.
- Newborn Hearing Impairment Screening: (a) a screening test for hearing loss from birth through the date a covered child is 30 days old; and (b) necessary diagnostic follow-up care related to the screening test from birth through the date a covered child is 24 months old. Benefits are subject to plan coinsurance but the deductible is waived.
- Care and treatment of an injury or sickness that in either case arises out of work for wages or profit where a covered person is not eligible for benefits under Workers' Compensation or similar type program. (This applies ONLY if you elect Occupational Coverage.)
- Reconstructive Surgery for Craniofacial Abnormalities to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease for a covered child from birth through the date the child is 18 years of age.

**Acquired Brain Injury**—a charge for an acquired brain injury.

**Adult Routine Physical Exam**—a charge for one routine examination during a calendar year which includes charges for immunizations if administered and billed by a doctor's office.

**Ambulatory Surgical Center**—a charge by an ambulatory surgical center.

**Amino Acid Based Elemental Formulas**—if used for the diagnosis and treatment of conditions and disorders described in the Certificate of Insurance.

**Autism Spectrum Disorder**—a charge for the diagnosis and treatment of Autism Spectrum Disorder from the date of diagnosis until the end of the child's ninth year.

**Cardiovascular Disease Tests for Early Detection**—a charge for certain noninvasive tests for atherosclerosis and abnormal artery structure performed by a laboratory certified by a national organization and recognized by the Louisiana Commissioner.

**Cervical Cancer/Human Papillomavirus**—a charge for an annual medically recognized diagnostic examination for the early detection of cervical cancer for women age 18 years and older.

**Chemical Dependency Treatment Facility**—a charge by a chemical dependency treatment facility.

**Colorectal Cancer Screening**—a charge for a colorectal cancer screening for a covered person age 50 and over.

**Crisis Stabilization Unit**—a charge by a crisis stabilization unit.

**Mastectomy/Reconstructive Surgery**—a charge for inpatient care for at least a 48 hour hospital stay following a mastectomy and 24 hours following a lymph node dissection, unless the physician and the patient agree on earlier discharge. Charges also include reconstruction of the breast on which the mastectomy was performed, surgery to produce a symmetrical appearance, prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedema.

**Outpatient Contraceptive Devices**—a charge for consultation, examination, procedure or medical service that is provided on an out-patient basis and related to the use of a drug or device intended to prevent pregnancy.

**Phenylketonuria or Other Heritable Diseases**—charges for formulas necessary for the treatment of "phenylketonuria" or other "heritable diseases" when prescribed or ordered by a physician.

**Prescription Drugs/Medicines** – a charge for (1) a drug and/or medicine prescribed or ordered by a Physician and dispensed only by a licensed pharmacist, including but not limited to prescription contraceptive drugs and devices and (2) injectable insulin.

**Prosthetics/Orthotics** - a charge for prosthetic devices, orthotic devices and professional services related to the fitting and use of those devices.

**Psychiatric Day Treatment Facility** – a charge by a Psychiatric Day Treatment Facility.

**Residential Treatment Center for Children and Adolescents** – a charge by a child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents.

**Routine Patient Care in Clinical Trials** - Charges for routine patient care costs in connection with a phase I through phase IV clinical trial.

**Serious Mental Illness** – a charge for psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM) I I I-R and set forth in the Certificate of Insurance.

**Telehealth Service** – a charge for Medical Care provided by Telehealth Services.

**Telemedicine Medical Service**—a charge for medical care provided by a physician for Telemedical Medical Services.

## Limitations

The following are in addition to limits shown in the Outline of Coverage.

### Limit on Charges for Chemical Dependency

Chemical dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance. The maximum overall benefit amount for chemical dependency is limited to three separate series of treatments for each covered person. A series of treatments means a planned, structured, and organized program (without lapse or interruption) in a covered facility to promote chemical-free status. Charges do not apply toward the out of pocket maximum.

### Limit on Charges for Dental Care

Charges for dental care shall be covered charges only to the following extent and must be for care rendered by a Physician.

- Emergency repair due to Injury to sound natural teeth. Setting of a jaw fracture or dislocation due to Injury. Treatment must be made while coverage is in effect and begun within 90 days from the date of an accident and charges for treatment must be incurred within one year of the accident.
- Removing impacted teeth that are not completely erupted up to a maximum of \$100 per tooth.
- Care and treatment of cyst, malignant tumors, leukoplakia or
- Correction of harelip, cleft palate or protruding mandible.
- Freeing of a muscle attachment.

No charges shall be covered for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, preparing the mouth for the fitting of or the continued use of dentures or orthognathic surgery.

### Exclusions:

- Any loss due to an act of war, declared or undeclared;
- Care or treatment of an injury or sickness that in either case arises out of work for wages or profit where a covered person is covered for benefits under worker's compensation or similar type program;
- Care, treatment or supplies that are either medically unnecessary or experimental in nature;
- The part of an expense that is in excess of the plan maximum;
- Care and treatment as a result of participating in a riot or that results from an attempt to commit, or from committing, an assault or crime by a Covered Person.
- Care, treatment or x-ray exams for mouth conditions that: (a) are due to periodontal or periapical disease; or (b) involve any of the teeth or surrounding tissue or structure; or (c) involve the alveolar process or gingival tissue. This exclusion shall not apply to the extent that dental care and treatment are included under the Benefit Provisions;
- Care and treatment for which there would not have been a charge if no insurance had been in force;
- Care and treatment provided mainly for cosmetic reasons including complications that result. This exclusion shall not apply if the care and treatment: (a) is for repair of damage from an accident that occurred while the person is covered under this plan; or (b) the surgery is begun within 90 days after the accident and the charges for such surgery are incurred within one year after the accident or (c) is due solely to surgical removal related to all or part of the breast tissue because of an injury to or Sickness of the breast, and related surgery on a non-diseased breast in order to restore or achieve a symmetrical appearance; or (d) is to correct a congenital anomaly in a child born while covered under this policy;
- Lenses for the eyes and exams for their fittings and hearing aids and exams for their fittings; this exclusion shall not apply to the extent vision or hearing care and treatment are included under this program.
- Services or supplies provided mainly as a rest cure, maintenance, or custodial care;
- Treatment of weak, strained, flat, unstable or unbalanced feet; corns, calluses, or toenails; treatment of an metatarsalgia or bunion or orthopedic shoes and any other devices except as stated in the Diabetes Equipment & Supplies item in the Other Medical Services and Supplies section of this brochure.

### Exclusions continued:

- A charge for an immunization when required for travel.
- Services that are of the nature of educational or vocational testing or training;
- Air conditioners, air purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electrical heating units, swimming pools, orthopedic mattresses, exercising equipment, vibratory equipment, elevator or chair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, wigs and devices for simulating natural female body contours, except for an initial device following mastectomy surgery;
- Exogenous or morbid obesity except for treatment of medical endogenous obesity;
- Sex transformations,
- Surgical sterilizations or reversal thereof or elective abortions;
- Treatment of infertility, including, but not limited to artificial insemination, in vitro fertilizations, and development of an embryo or implant of embryo developed in vitro;
- Pregnancy, other than a Complication of Pregnancy;
- Corrective shoes or other corrective devices or appliances, except as described in the Certificate of Insurance;
- Radial keratotomy;
- Care and treatment for injury sustained while under the influences of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a physician;
- Care and treatment in an emergency room of a hospital except for accidental injuries or emergency care specified in the policy;
- Personal or home based artificial kidney equipment;
- Private-duty professional nursing care which is not prescribed by a doctor and not a part of a Home Health Care Plan or Hospice Care Plan;
- Any care, treatment or services incurred before coverage is effective or after coverage ends unless otherwise provided;
- Any care, treatment or services associated with a condition which is specifically named by rider as excluded;
- Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to any state Medicaid program, care provided by a medical assistance program and where prohibited by law or for the support, maintenance and treatment of mental illness or mental retardation provided by a tax-supported institution of the State of Texas, including community centers for mental health and mental retardation.
- Newborn infant care unless such charge is incurred for the infant's injury or sickness or as described in the Child Health Supervision Services, Childhood Immunizations and Newborn Screening Test for Hearing Impairment subsection of the Eligible Expenses section of the Group Policy.

## Group Term Life and Accidental Death and Dismemberment Insurance

*Southern Farm Bureau Health Care* includes Group Term Life and Accidental Death & Dismemberment Insurance (“AD&D”) for the Member only. No dependent life insurance or dependent AD&D insurance is included in this program. Your Life and AD&D Insurance will terminate on the first day of the month following attainment of age 65.

### Term Life

Benefit Amount: \$10,000  
Member’s Age: 18 through 64

Benefits for loss of your life are payable to the beneficiary designated by you. If you have not named a beneficiary, payment may be made to your estate. No benefit will be paid for death due to an act of war, declared or undeclared; commission of a felony; or suicide within two years of the covered Member’s effective date.

A conversion privilege is available when the Member’s Term Life Insurance ceases, due to loss of eligibility. However, no conversion is allowed for life insurance, which ceases solely due to non-payment of premium. Refer to the Group Certificate for additional details.

### AD&D Benefit

In the event of loss due to accidental bodily injury the AD&D principal sum (an amount equal to the Term Life amount) will be paid.

In the Event of Loss of:	The Benefit Shall be:
Life	The Principal Sum Amount
Both hands or feet	The Principal Sum Amount
Sight of both eyes	The Principal Sum Amount
One hand and one foot	The Principal Sum Amount
One hand and sight of one eye	The Principal Sum Amount
One foot and sight of one eye	The Principal Sum Amount
One hand	One Half of The Principal Sum Amount
One foot	One Half of The Principal Sum Amount
Sight of one eye	One Half of The Principal Sum Amount

Not more than the Principal Sum Amount is payable for all covered losses of a covered person in any one accident. A covered loss must occur no later than 90 days after the date of the accident.

“Loss” with respect to a hand or foot means severance at or above the wrist or ankle joint.

“Loss” with respect to the sight of an eye means the total and unrecoverable loss of sight.

## Exclusions

A loss that is directly or indirectly a result of or contributed to by one of the following is not a Covered Loss even though it was caused by an accidental bodily injury:

- An Injury which occurred before the Covered Member was insured for such coverage.
- A disease or infirmity of the mind or body
- Ptomaine or bacterial infections, except pus-forming infections that result from an Injury, which these Exclusions do not exclude
- Medical or surgical treatment, except where it is both: (a) treatment of an Injury that meets the tests of a Covered Loss; and (b) treatment is performed within 90 days after the Injury.
- Insurrection; an act of war, declared or undeclared.
- Unlawful participation in a riot.
- An attempt to commit, or committing, an assault or felony by the Covered Member.
- Intentionally self-inflicted Injury.
- Suicide or attempted suicide whether, in either case, sane or insane.
- Operating, riding in or descending from any kind of aircraft:
  - a. As a passenger on any kind of aircraft operated by or for the armed forces;
  - b. As a pilot or crew member in any kind of aircraft. A crew member is anyone who has duties at any time on the flight involving either the flight or the aircraft;
  - c. As a participant in aviation training; or
  - d. As a participant in a sporting event or hobby which involves operating, riding in or descending from any kind of aircraft
- Voluntary or involuntary:
  - a. Taking of any poison or drugs (including but not limited to narcotics, hypnotics, and amphetamines);
  - b. Asphyxiation from or inhalation of gas.
- Homicide

## Benefit Termination

The accidental death and dismemberment benefit terminates on the end of the month in which the Member reaches age 65.

## Conversion

No conversion privilege exists for accidental death and dismemberment insurance.

The Group Term Life and AD&D Insurance Plans are underwritten by Southern Farm Bureau Life Insurance Company, Jackson, Mississippi on policy form GMR. The member will receive a Certificate of Insurance evidencing coverage under G-00419-G on policy form GMR-FACE.

# NOTES

# NOTES

# NOTES



Most people (and you are probably no exception) cannot conceive that they, or members of their family, are subject to serious problems arising from ill health or injury. We know, however, such an event is possible. *Southern Farm Bureau Health Care* offers Major Medical Group Insurance plans that feature sound, adequate coverage and offer solid value for each dollar that you and your family spend for health care protection. The program includes pre-admission certification, large case management, prescription drug services and a Preferred Provider Organization to help manage health care costs. *Southern Farm Bureau Health Care* offers a High Deductible Health Plan that qualifies for use with a Health Savings Account (HSA) and is dedicated to giving prompt personal attention to your health care needs. Benefits provided depend upon the plan selected. Premium rates vary by plan.

***Southern Farm Bureau Health Care* is administered by Gilsbar, Inc. Founded in 1959, Gilsbar, is recognized as a leader in the management of health and life insurance programs for large groups and associations.**



P.O. Box 790 • Covington, LA 70434

For personal attention to your questions or for professional assistance call toll-free  
1-800-999-8932 • Fax: 1-985-871-1878 • E-mail: [gilsbar@gilsbar.com](mailto:gilsbar@gilsbar.com)



## Southern Farm Bureau Life Insurance Company

P.O. Box 78 • Jackson, MS 39205 • (601) 981-7422 • [www.sfbli.com](http://www.sfbli.com)

Policy Form GMR-FACE-G-00419

This brochure is a summary of the benefits under the program described herein. The group health insurance program offered to Texas Farm Bureau members has been named "*Southern Farm Bureau Health Care*" and is referred to throughout this brochure by that name. The member will receive a Certificate of Insurance evidencing coverage under G-00419-G on policy form GMR-FACE that contains details pertaining to the coverage. The exact provisions governing the insurance are contained in the Group policy filed in Texas. The policy is issued on Policy Form GMR-FACE.

The Major Medical Group Insurance Plans are underwritten by *Southern Farm Bureau Life Insurance Company*, Jackson, MS on policy form GMR-FACE. Health Savings Accounts (HSA) are subject to limitations and restrictions under the Medicare Prescription Drug Improvement and Modernization Act of 2003. This brochure is not intended as tax or legal advice. We strongly urge you to consult with your accountant or tax advisor before starting an HSA to determine if this is a proper savings vehicle for you. *Southern Farm Bureau* bears no responsibility for the establishment or administration of any HSA.

30 day free look: After you receive your Certificate of Insurance, read it carefully. If you are not completely satisfied, return it without claim within 30 days after receipt. Your full premium will be refunded immediately, no questions asked.