ADVANCED CHOICE SCHEDULE OF BENEFITS
(for individuals & families)

THIS SCHEDULE IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Indiana Farm Bureau® Health Plans

TELADOC®

This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. Indiana Farm Bureau Health Plans use UnitedHealthcare Choice Plus network of providers. Please keep in mind that in-network payments are based on negotiated fees; if an out-of-network provider is used, the individual's liability will increase significantly.

	In-Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD) • Per individual, per calendar year. • Unless otherwise indicated, all benefits are subject to the CYD.	**Option 1:** $1,500 per individual **Option 2:** $3,000 per individual	
OUT OF POCKET MAXIMUM (OOP) • Once the OOP maximum is met, eligible benefits are provided at 100% for an individual for the remainder of the calendar year. • This applies to in-network provider services only. • Copayments do not apply to OOP and must still be paid after OOP is met.	For $1,500 CYD: **Option 1:** $5,000 for individual coverage / $10,000 for family coverage For $3,000 CYD: **Option 2:** $10,000 for individual coverage / $20,000 for family coverage	Unlimited
LIFETIME BENEFIT MAXIMUM	Unlimited	

Services

	In-Network		Out-of-Network	
OFFICE VISIT	**Option 1** For $1,500 CYD: $30 copayment* per visit **Option 2** For $3,000 CYD: $40 copayment* per visit		CYD/Coinsurance	
TELADOC®	$0 copayment per visit		No Coverage	
COINSURANCE • Based on the maximum allowable charge	**Plan Pays** 80%	**Your Responsibility** 20%	**Plan Pays** 60%	**Your Responsibility** 40%
PREVENTATIVE CARE BENEFITS • No waiting period • In-network benefits not subject to CYD	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Preventative Health Exam[1]	100%	0%	60%	40%
• Annual Well-Woman Exam[2]	100%	0%	60%	40%
• Routine Colonoscopy[3]	100%	0%	60%	40%
• Annual Routine PSA[4]	100%	0%	60%	40%
PRESCRIPTION DRUG COVERAGE	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Generic - 30 day supply	All but copayment	$4 copayment[5]	60%	40%
• Brand	80%	20%	60%	40%
• $7,500 individual maximum per calendar year				
EMERGENCY ROOM SERVICES • Not resulting in admission	$300 Deductible per visit (In addition to CYD and Coinsurance)			

DENTAL - All Individuals

Routine dental services, including two exams, cleanings, x-rays and fillings per calendar year
- Subject to a six month waiting period
- There is a copayment per visit and a $500 calendar year maximum per individual per calendar year.

VISION

Pediatric (Under Age 19) Routine vision benefits including eye exams, eyeglasses and contact lenses.

- No waiting period.
- Eye exams are covered at 100% once every calendar year, no dollar limit.
- Eyeglass frames, eyeglass lenses or contact lenses are covered once every calendar year at 100% up to a maximum of $100 per member, not subject to deductible and coinsurance.

Age 19 and Over - Routine vision benefits including eye exams, eyeglasses and contact lenses

- Subject to a six month waiting period.
- Eye exams are covered once every calendar year with a $40 limit per individual.
- Eyeglass lenses or contact lenses are covered once every calendar year at 100% up to a maximum of $100 per individual, not subject to deductible.

FOOTNOTES

1. Preventative health exam for adults and children and related services as outlined below and performed by the physician during the preventative health exam or referred by the physician as appropriate, including:
   - Screenings and counseling services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF).
   - Bright Futures recommendations for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA).
   - Preventative care and screening for women as provided in the guidelines supported by HRSA and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC).
2. Annual well-woman exam
   - Routine well-woman preventative exam office visit
   - Cervical cancer screening
   - Screening mammography at age 40 and older, with one baseline mammogram between the ages of 35 and 39
   - Other USPSTF screenings with an A or B rating
   - Pap smears
   - Bone density measurement screening
3. Colorectal cancer screening as recommended by the United States Preventive Services Task Force (USPSTF).
4. Prostate cancer screening for men age 50 and older.
5. Prescription copayment does not apply toward deductibles or out-of-pocket maximums.

*OFFICE COPAYMENT GUIDELINES

A copayment will be applied to each office visit for the covered services performed in the office and provided and billed by a physician who is an in-network provider. The remaining charges for covered services rendered during the office visit will be paid at 100% of the maximum allowable charge. If a physician who is an out-of-network provider is utilized for covered services, benefits will be determined on the basis of the out-of-network coinsurance percentage after deductible is met. Copayments will not be applied toward deductibles or out-of-pocket maximums.

Copayments do not apply to the following services: advanced radiological imaging, allergy testing and injections, biopsy interpretation, bone density testing, cardiac diagnostic testing, chemotherapy services, chiropractic services, complex diagnostic services, dental services except preventative and restorative for all individuals, diagnostic services sent out, durable medical equipment, growth hormone injections, IV therapy, Lupron injections, mammography, maternity services, nerve conduction studies, neuropsychological or neurological tests, nuclear cardiology, nuclear medicine, orthotics, preventative services as indicated in the contract, prosthetics, provider administered specialty pharmacy products, sleep studies, surgery performed in a physician's office and related surgical supplies, Synagis injections, therapeutic/rehabilitative services, ultrasounds and vision services. These services are subject to the terms and conditions of the contract. Deductibles and coinsurance will apply except where otherwise indicated.

MATERNITY BENEFITS

Maternity benefits will be provided after an individual's coverage on a family contract has been in effect for nine consecutive months. Individual coverage has NO maternity benefits except for complications of pregnancy.

PRE-EXISTING CONDITION WAITING PERIOD

Benefits will not be provided for any pre-existing condition until an individual has completed a waiting period of at least six months. In rare circumstances, the pre-existing condition waiting period may be longer. A pre-existing condition is defined in the contract as "An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under this contract for which: Medical advice or treatment was recommended by, or received from, a provider of health care services; or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment."

Additional waiting periods may apply as indicated in the contract.

PLAN ENHANCEMENTS

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Health Plans

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