MAJOR MEDICAL 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.

SOUTH DAKOTA FARM BUREAU® Health Plans

TELADOC.

This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. South Dakota Farm Bureau Health Plans uses 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 member's liability will increase significantly.

	In-Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD)[1] • Unless otherwise indicated, all benefits are subject to the CYD.	$7,500 per individual	
OUT OF POCKET MAXIMUM (OOP)[2] • 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.	$15,000 individual $30,000 family	Unlimited
LIFETIME BENEFIT MAXIMUM	Unlimited	

Services

	In-Network		Out-of-Network	
COINSURANCE · Based on the maximum allowable charge.	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
	80%	20%	60%	40%
PREVENTATIVE CARE BENEFITS · Subject to CYD	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Well-Child Services[3]	80%	20%	Not Covered	
• Routine Colonoscopy[4]	80%	20%	60%	40%
• Annual Routine PSA[5]	80%	20%	60%	40%
• Annual Routine OB/GYN Exam[6]	80%	20%	Not Covered	
• Annual Routine Pap Smear[7]	80%	20%	60%	40%
• Mammogram[8]	80%	20%	60%	40%
PRESCRIPTION DRUG COVERAGE	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Generic - 30 day supply	All but copayment	$4 copayment[9]	60%	40%
• Brand	80%	20%	60%	40%
• Unlimited Calendar Year Maximum Per Individual				
TELADOC · Not subject to CYD	$0 copayment per visit		No Coverage	

FOOTNOTES

1. Deductible – the dollar amount of covered services that must be incurred and paid first by an individual each calendar year before plan benefits begin.
2. Once the OOP maximum is met, benefits are provided at 100% for an individual(s) for the remainder of the calendar year. This applies to in-network provider services only. There is no Out of Pocket Maximum when out-of-network providers are used.
3. Benefits are available, subject to deductible and coinsurance, for an individual under the age of 7 for physical examinations and appropriate immunizations/vaccinations when services are rendered by an in-network provider. Exams not used during the time periods below do not carry over to the next time period.

AGE	NUMBER OF EXAMS
Under age one	Four exams from birth to the child's first birthday
Age one	Two exams from the child's first birthday to the child's second birthday
Age two through six	One exam per year (determined by the child's birthday)

4. Benefits will be provided for colorectal cancer screening as recommended by the United States Preventive Services Task Force (USPSTF) when provided by an in-network or out-of-network provider, subject to the deductible and coinsurance.
5. Benefits will be provided, subject to deductible and coinsurance, for one routine PSA per calendar year when services are rendered by an independent laboratory or other outpatient setting.
6. Benefits will be available for one routine OB/GYN exam per calendar year, subject to deductible and coinsurance. Services must be rendered by an in-network physician's office and billed by the in-network provider. Related pathology, including pap smear, which is provided as a part of the routine OB/GYN exam, will be covered when the services are rendered by an in-network physician's office and billed by the in-network provider. Related pathology that the physician sends to an independent laboratory will be subject to deductible and coinsurance. No benefit is available for routine OB/GYN exams provided by an out-of-network provider.
7. Benefits will be provided for the interpretation of one routine pap smear per calendar year when services are rendered by an independent laboratory or other outpatient setting, subject to deductible and coinsurance.
8. Benefits will be provided, subject to deductible and coinsurance, for routine mammography screening provided such examinations are conducted upon the recommendation of the individual's physician. One baseline routine mammogram will be allowed for individuals between the ages of 35-39. One routine mammogram will be allowed annually for individuals age 40 and above. All routine mammography screens are subject to deductible and coinsurance.
9. Prescription copayment does not apply toward deductible or out-of-pocket maximum.

MATERNITY BENEFITS

Maternity Benefits will be available after an individual's coverage on a family contract has been in effect for nine consecutive months. Individual coverage has NO maternity benefits.

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 12 months. 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."