SOUTH DAKOTA FARM BUREAU®
Health Plans

SOUTH DAKOTA FARM BUREAU
TRADITIONAL HEALTH PLANS

LiveWellSD.com

1-833-480-2188

Visit your local Farm Bureau Financial Services agent

WELCOME TO LOWER HEALTH PREMIUMS

We've been looking out for South Dakota's #1 industry for over 100 years. As a voice for farmers and ranchers across the state, we're now extending that voice by offering affordable health plans for our members. Most will save over 35% on their premiums.

The best part? You don't have to be a farmer or rancher to join South Dakota Farm Bureau, and membership starts at only $60/year.

If you're under 65 years of age, SDFB Health Plans has a range of plan options for a healthier South Dakota. Choose your:

- Level of coverage
- Deductible
- Out-of-pocket payments
- Preventative health benefits

Apply for coverage at any time without waiting for an enrollment period. You'll also get personal customer service you can trust from our South Dakota Farm Bureau Health Plans representatives. So, if you ever have questions, we're standing by ready to help. Our Health Plans rely on the UnitedHealthcare Choice Plus network and physicians can be found at most health care providers across the state – and even the nation.

PLAN OPTIONS

Here's an overview of all South Dakota Farm Bureau Health Plans. Each plan has different terms depending on whether you choose to use in-network or out-of-network providers. These plans require medical underwriting that may affect eligibility and rates. South Dakota Farm Bureau membership is required.

ADVANCED CHOICE

An Advanced Choice plan for families or individuals offers peace of mind coverage and includes limited dental and vision benefits. With this plan you get a choice of two different deductible amounts.

CLASSIC CHOICE

Classic Choice is for those who are looking for a health plan with preventative health, dental and vision benefits. Get the trifecta -- health, limited dental and vision -- under one health plan. Available for individuals only.

MAJOR MEDICAL

Our Major Medical plan is ideal for those who want catastrophic protection with the advantage of a lower premium. This plan provides benefits for physician services, hospitalization, prescription drugs and more. Available for individuals or families.

HIGH DEDUCTIBLE HEALTH PLAN (HSA-QUALIFIED)

South Dakota Farm Bureau Health Plans offers a range of High Deductible Health Plans (HDHP) which meet all federal requirements necessary to open a Health Savings Account (HSA).

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.

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) • 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 · Not subject to CYD	**Option 1** For $1,500 CYD: $25 copayment* per visit **Option 2** For $3,000 CYD: $35 copayment* per visit		CYD/Coinsurance	
TELADOC · Not subject to CYD	$0 copayment per visit		No Coverage	
TELADOC EXPERT MEDICAL SERVICES · Not subject to CYD	$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	$75 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 yea
- 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 lense

- 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 visi
   - 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 for individuals age 45 and older.
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 contract, prosthetics, provider administered specialty pharmacy products, sleep studies, surgery performed in a physician's office the 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." The pre-existing condition waiting period will not apply to individuals under the age of 19 enrolled as dependents in a family coverage.

Additional waiting periods may apply as indicated in the contract.

CLASSIC CHOICE SCHEDULE OF BENEFITS
(for individuals)

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) • Unless otherwise indicated, all benefits are subject to the CYD.	**Option 1:** $3,000 per individual **Option 2:** $6,000 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).	**Option 1:** $10,000 **Option 2:** $20,000	Unlimited
LIFETIME BENEFIT MAXIMUM	Unlimited	

Services

	In-Network		Out-of-Network	
OFFICE VISIT · Not subject to CYD	**Option 1** For $3,000 CYD:	$40 copayment* per visit	CYD/Coinsurance	
	Option 2 For $6,000 CYD:	$40 copayment* per visit		
TELADOC · Not subject to CYD	$0 copayment per visit		No Coverage	
TELADOC EXPERT MEDICAL SERVICES · Not subject to CYD	$0 copayment per visit		No Coverage	
COINSURANCE · Based on the maximum allowable charges for eligible benefits	**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%
• Unlimited Calendar Year Maximum Per Individual				
EMERGENCY ROOM SERVICES · Not resulting in admission	$75 Deductible per visit (In addition to CYD and Coinsurance)			

DENTAL - No waiting periods

Pediatric (Under Age 19)

- Preventative services, as outlined by the U.S. Preventative Task Force (USPTF) and Health Resources and Services Administration (HRSA)
- Other eligible dental services subject to CYD and coinsurance
- Limited orthodontic care

Age 19 and Over

- $40 copay for preventative and restorative services
- Maximum benefit per calendar year is $500

VISION

No waiting periods

Pediatric (Under Age 19)

- Eye exams are covered at 100% once every calendar year.
- 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

- Eye exams are covered once every calendar year with a limit of $40.
- 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 Preventative 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 of 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 35-39
   - Other USPSTF screenings with an A or B rating
     - Pap smears
     - Bone density measurement screening
3. Colorectal cancer screening for individuals age 45 and older
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 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 age 19 and over, 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/ habilitative 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. Copayments will not be applied to the deductibles or out-of-pocket maximums.

MATERNITY BENEFITS

Maternity benefits will be eligible as long as the pregnancy is not considered a pre-existing condition.

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. 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."

HIGH DEDUCTIBLE HEALTH PLAN 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 apply toward CYD. • Family Deductible can be satisfied by one or more covered individuals during a calendar year. • In-Network and Out-of-Network deductibles are met separately.	$1,500 for individual $2,500 for individual $3,000 for family $5,000 for 2-person/3-person/family	$1,500 for individual $2,500 for individual $3,000 for family $5,000 for 2-person/3-person/family
OUT OF POCKET MAXIMUM (OOP)[2] • Family Out of Pocket Maximum can be satisfied by one or more covered individuals during a calendar year. • Once the OOP maximum is met, eligible benefits are provided at 100% for the remainder of the calendar year. • This applies to in-network provider services only.	$3,000 for $1,500 deductible $3,750 for $2,500 deductible $6,000 for $3,000 deductible $7,500 for $5,000 deductible	Unlimited
LIFETIME BENEFIT MAXIMUM	Unlimited	

Services

	In-Network		Out-of-Network	
COINSURANCE · Based on the maximum allowable charges for eligible benefits.	**Plan Pays** 80%	**Your Responsibility** 20%	**Plan Pays** 60%	**Your Responsibility** 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[9]	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Generic and Brand Prescriptions	80%	20%	60%	40%
• Unlimited calendar year maximum per individual				
• Home Delivery Services are available				

TELADOC

Member must pay 100% of the current Teladoc consultation fee until CYD is met. Once CYD is met, no consultation fee for Teladoc. All Teladoc Expert Medical Services are at no charge.

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 (on plan deductibles $3,000 and $5,000) 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 one routine colonoscopy every four years for individuals age 50 and over 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. 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. Benefits will be provided, subject to deductible and coinsurance.

MATERNITY BENEFITS

Maternity Benefits will be available after an individual's coverage on a 2-person, 3-person or 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." The pre-existing condition waiting period does not apply to individuals under the age of 19 on a family plan.

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.

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	In-Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE (CYD)[1] • Unless otherwise indicated, all benefits are subject to the CYD.	$5,000 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.	$10,000 individual $20,000 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	
TELADOC EXPERT MEDICAL SERVICES · 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 one routine colonoscopy every four years for individuals age 50 and over 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." The pre-existing condition waiting period does not apply to individuals under the age of 19 enrolled in a family plan.

PLAN ENHANCEMENTS

TELADOC

TELADOC provides access to doctors by phone or video, as part of your benefits. Our U.S. board-certified doctors can diagnose, treat and even prescribe medicine, if needed, for a wide range of medical needs, including the flu, allergies, rash, upset stomach and much more.

Expert Medical Services is another valuable service from Teladoc. This benefit offers expert medical advice available at no cost to you and/or your eligible dependents. Expert Medical Services can provide answers to medical questions, a confirmation or modification of a diagnosis, guidance on picking a treatment option, or help deciding if a surgery is right for you.
teladoc.com | 1-800-Teladoc

Optum Rx®

OptumRx® HOME DELIVERY is an option for all members and is safe and reliable. You may pay less for your medication with a three-month supply through OptumRx. Get convenient, free standard shipping on medications delivered to your mailbox.
1-800-788-4863, TTY 711 to place home delivery orders anytime.

LIVE WELL

Finding ways to stay healthy doesn't have to be difficult. Healthy choices are all around us every day. FBHP has teamed with UMR Wellness CARE to offer a Clinical Health Risk Assessment to help you recognize and make the most of your health care opportunities. Additional wellness resources are available at **umr.com**, including a library of health information, videos and interactive "action plan" tutorials to help you get and stay healthy.

CARE

The Maternity CARE Program informs members who are thinking about having a baby or are in the early stages of pregnancy about how improving their own health can influence the future health of their baby.

With the CARE app, members can access a wide range of wellness information to improve overall health and wellbeing.

Getting started is easy

Enroll today! We'll need some basic information along with an email address, mobile phone number and your UMR member ID and group ID numbers. Simply scan the **QR code** or access the enrollment page at **go.umr.com/get-care-app**

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talkspace

Talkspace Programs | Mental Health Care for All
Talkspace's therapist-led virtual care services and same-day start times can provide responsive and reliable mental health support to those experiencing a wide range of challenges - including stress, anxiety, depression and more.
talkspace.com/connect

*Deductibles and co-pays apply

NurseLine℠

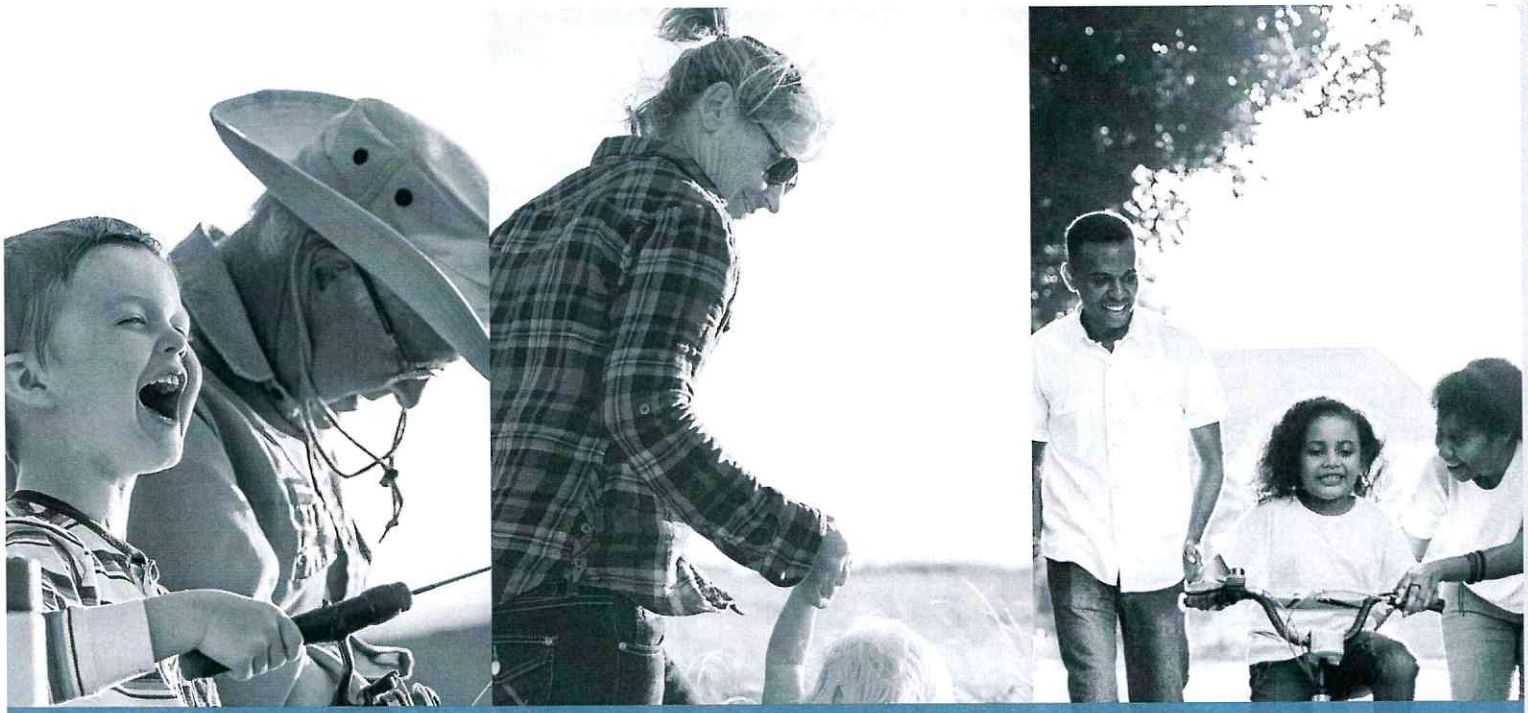
NurseLine will connect you to a team of registered nurses who can answer your questions and provide advice. Nurses are standing by to help any time of day, seven days a week as part of your UMR health benefits, at no cost to you.

Reach out by phone using the toll-free number on the back of your member ID card or chat online with a nurse at umr.com, select Health Center from myMenu and look for the link in the "I need to..." section. You have questions, UMR nurses have answers.

*Deductibles and co-pays apply

SOUTH DAKOTA FARM BUREAU®

Health Plans



LiveWellSD.com

1-833-480-2188

Visit your local Farm Bureau Financial Services agent

MH-SD-CM-LT21-235

See & Compare Plans

Advanced Choice $1,500

Hide this plan

Preference Match	Plan Benefits (View Details)	Estimated annual cost	
Add your preferences	**Calendar Year Deductible (CYD)** $1,500 per member **Coinsurance** 80% **Out of Pocket Maximum** $5,000 Individual / $10,000 Family **Office Visit Copay** $25 Copay	Min $5,694 Est **$6,467** Max N/A	Add plan to compare Estimated Rate $474.50 / mo Add to Cart

Advanced Choice $3,000

Hide this plan

Preference Match	Plan Benefits (View Details)	Estimated annual cost	
Add your preferences	**Calendar Year Deductible (CYD)** $3,000 per member **Coinsurance** 80% **Out of Pocket Maximum** $10,000 Individual / $20,000 Family **Office Visit Copay** $35 Copay	Min $4,665 Est **$5,438** Max N/A	Add plan to compare Estimated Rate $388.75 / mo Add to Cart

Classic Choice $3,000

Hide this plan

Preference Match	Plan Benefits (View Details)	Estimated annual cost	
Add your preferences	**Calendar Year Deductible (CYD)** $3,000 **Coinsurance** 80% **Out of Pocket Maximum** $10,000 **Office Visit Copay** $40 Copay	Min $5,931 Est **$6,704** Max N/A	Add plan to compare Estimated Rate $494.25 / mo Add to Cart

Classic Choice $6,000

Hide this plan

Preference Match	Plan Benefits (View Details)	Estimated annual cost	
Add your preferences	**Calendar Year Deductible (CYD)** $6,000 **Coinsurance** 80% **Out of Pocket Maximum** $20,000 **Office Visit Copay** $40 Copay	Min $4,386 Est **$5,159** Max N/A	Add plan to compare Estimated Rate $365.50 / mo Add to Cart

High Deductible Health Plan (HSA-Qualified) $1,500

Hide this plan

Preference Match | Plan Benefits | Estimated annual cost

View Details

Calendar Year Deductible (CYD)
$1,500 per member

Coinsurance
80%

Out of Pocket Maximum
$3,000

Office Visit Copay
Subject to CYD and Coinsurance

Add your preferences

Min	$5,055
Est	**$5,828**
Max	N/A

Add plan to compare

Estimated Rate
$421.25 / mo
Add to Cart

High Deductible Health Plan (HSA-Qualified) $2,500

Hide this plan

Preference Match

Add your preferences

Plan Benefits View Details

Calendar Year Deductible (CYD)
$2,500

Coinsurance
80%

Out of Pocket Maximum
$3,750

Office Visit Copay
Subject to CYD and Coinsurance

Estimated annual cost

Min	$4,041
Est	**$4,814**
Max	N/A

Add plan to compare

Estimated Rate
$336.75 / mo
Add to Cart

Major Medical $5,000

Hide this plan

Preference Match

Add your preferences

Plan Benefits View Details

Calendar Year Deductible (CYD)
$5,000 per member

Coinsurance
80%

Out of Pocket Maximum
$10,000 Individual / $20,000 Family

Office Visit Copay
Subject to CYD and Coinsurance

Estimated annual cost

Min	$2,604
Est	**$3,377**
Max	N/A

Add plan to compare

Estimated Rate
$217.00 / mo
Add to Cart

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 UnitedHealth care 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.	$5,000 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.	$10,000 individual $20,000 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	
TELADOC EXPERT MEDICAL SERVICES • 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 one routine colonoscopy every four years for individuals age 50 and over 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." The pre-existing condition waiting period does not apply to individuals under the age of 19.

HIGH DEDUCTIBLE HEALTH PLAN 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 UnitedHealth care 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 apply toward CYD. • Family Deductible can be satisfied by one or more covered individuals during a calendar year. • In-Network and Out-of-Network deductibles are met separately.	$1,500 for individual $2,500 for individual $3,000 for family $5,000 for 2-person/3-person/family	$1,500 for individual $2,500 for individual $3,000 for family $5,000 for 2-person/3-person/family
OUT OF POCKET MAXIMUM (OOP)[2] • Unless otherwise indicated, all benefits apply toward CYD. • Family Out of Pocket Maximum can be satisfied by one or more covered individuals during a calendar year. • In-Network and Out-of-Network deductibles are met separately.	$3,000 for $1,500 deductible $3,750 for $2,500 deductible $6,000 for $3,000 deductible $7,500 for $5,000 deductible	Unlimited
LIFETIME BENEFIT MAXIMUM	Unlimited	

Services

	In-Network		Out-of-Network	
COINSURANCE • Based on the maximum allowable charges for eligible benefits. • Family deductible can be satisfied by one or more covered individuals during a calendar year.	Plan Pays: 80%	Your Responsibility: 20%	Plan Pays: 60%	Your Responsibility: 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[9]	Plan Pays	Your Responsibility	Plan Pays	Your Responsibility
• Generic and Brand Prescriptions	80%	20%	60%	40%
• Unlimited calendar year maximum per individual				
• Home Delivery Services are available				

TELADOC

Your Responsibility: Member must pay current Teladoc copay until CYD is met. Once CYD is met, no copay for Teladoc. All Teladoc Expert Medical Services are at no charge.

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 (on plan deductibles $3,000 and $5,000) 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 one routine colonoscopy every four years for individuals age 50 and over 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. 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. Benefits will be provided, subject to deductible and coinsurance.

MATERNITY BENEFITS

Maternity Benefits will be available after an individual's coverage on a 2-person, 3-person or 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." The pre-existing condition waiting period does not apply to individuals under the age of 19.

CLASSIC CHOICE SCHEDULE OF BENEFITS
(for individuals)

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 UnitedHealth care 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) • Unless otherwise indicated, all benefits are subject to the CYD.	**Option 1:** $3,000 per individual **Option 2:** $6,000 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).	**Option 1:** $10,000 **Option 2:** $20,000	Unlimited
LIFETIME BENEFIT MAXIMUM	Unlimited	

Services

	In-Network		Out-of-Network	
OFFICE VISIT · Not subject to CYD	**Option 1** For $3,000 CYD:	$40 copayment* per visit	CYD/Coinsurance	
	Option 2 For $6,000 CYD:	$40 copayment* per visit		
TELADOC · Not subject to CYD	$0 copayment per visit		No Coverage	
TELADOC EXPERT MEDICAL SERVICES · Not subject to CYD	$0 copayment per visit		No Coverage	
COINSURANCE · Based on the maximum allowable charges for eligible benefits	**Plan Pays** 80%	**Your Responsibility** 20%	**Plan Pays** 60%	**Your Responsibility** 40%
PREVENTATIVE CARE BENEFITS · No waiting period · 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%
• Unlimited Calendar Year Maximum Per Individual				
EMERGENCY ROOM SERVICES · Not resulting in admission	$75 Deductible per visit (In addition to CYD and Coinsurance)			

DENTAL - No waiting periods

Pediatric (Under Age 19)
- Oral risk assessment paid at 100%
- Other eligible dental services subject to CYD and coinsurance
- Limited orthodontic care

Age 19 and Over
- $40 copay for preventative and restorative services
- Maximum benefit per calendar year is $500

VISION

No waiting periods

Pediatric (Under Age 19)

- Eye exams are covered at 100% once every calendar year.
- 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

- Eye exams are covered once every calendar year with a limit of $40.
- 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 Preventative 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 of 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 35-39
   - Other USPSTF screenings with an A or B rating
     - Pap smears
     - Bone density measurement screening
3. Colorectal cancer screening for individuals age 45 and older
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 the out-of-network coinsurance percentage after deductible is met.

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 age 19 and over, 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 contract, prosthetics, provider administered specialty pharmacy products, sleep studies, surgery performed in a physician's office and related surgical supplies, Synagis injections, therapeutic/ rehabilitative/ habilitative services, ultrasounds and vision services. These services are subject to the terms and conditions of the contract and deductibles and coinsurance will apply except where otherwise indicated. Copayments will not be applied to the deductibles or out-of-pocket maximums.

MATERNITY BENEFITS

Maternity benefits will be eligible as long as the pregnancy is not considered a pre-existing condition.

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. 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."

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.

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 UnitedHealth care 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) • 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 · Not subject to CYD	**Option 1** For $1,500 CYD: $25 copayment* per visit **Option 2** For $3,000 CYD: $35 copayment* per visit	CYD/Coinsurance
TELADOC · Not subject to CYD	$0 copayment per visit	No Coverage
TELADOC EXPERT MEDICAL SERVICES · Not subject to CYD	$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 · Not subject to CYD	In-Network: Plan Pays	In-Network: Your Responsibility	Out-of-Network: Plan Pays	Out-of-Network: 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	In-Network: Plan Pays	In-Network: Your Responsibility	Out-of-Network: Plan Pays	Out-of-Network: 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	$75 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 for individuals age 45 and older.
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 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 and 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." The pre-existing condition waiting period will not apply to individuals under the age of 19 enrolled as dependents in a family coverage.

Additional waiting periods may apply as indicated in the contract.