CORE 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.

Farm Bureau HEALTH PLANS Tennessee

Teladoc HEALTH

This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. Farm Bureau Health Plans uses the 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.

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

	In-Network	Out-of-Network
OUT-OF-POCKET (OOP) MAXIMUM • Once the OOP maxiumum 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 the OOP and must still be paid after the OOP is met	**Option 1** For $1,500 CYD: $7,500 Per Individual / $15,000 Per Family **Option 2** For $3,000 CYD: $15,000 Per Individual / $25,000 Per Family	Unlimited

LIFETIME BENEFIT MAXIMUM — Unlimited

Services

	In-Network	Out-of-Network
OFFICE VISIT (Not subject to CYD)	**Option 1** For $1,500 CYD: $30 Copay* Per Visit **Option 2** For $3,000 CYD: $40 Copay* Per Visit	CYD/Coinsurance
TELADOC (Not subject to CYD)	$0 Copay Per Visit	No Coverage

COINSURANCE (After CYD and based on maximum allowable charge)	In-Network Plan Pays	In-Network Your Responsibility	Out-of-Network Plan Pays	Out-of-Network Your Responsibility
	80%	20%	60%	40%

PREVENTATIVE CARE BENEFITS (No waiting period; In-Network benefits 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[2]	100%	0%	60%	40%
Routine Colonoscopy[3]	100%	0%	60%	40%
Annual Routine PSA[4]	100%	0%	60%	40%

PRESCRIPTION DRUG COVERAGE

- $7,500 Maximum Per Individual
- Generic - Farm Bureau Health Plans will reimburse 100% of the maximum allowable charge after CYD
- Brand Name - Farm Bureau Health Plans will reimburse 75% of maximum allowable charge after CYD
- Home Delivery Avaliable

EMERGENCY ROOM SERVICES (Not resulting in admission) — $300 Deductible Per Visit (In addition to CYD and Coinsurance)

DENTAL - (All Individuals)

Benefits include 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 frames, lenses and contact lenses

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

Age 19 and Over - Routine vision benefits including eye exams, eyeglasses frames, lenses 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 frames, lenses and contact lenses are covered once every calendar year at 100% up to a maximum of $100 per individual, not subject to deductible and coinsurance

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
   - 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
   - 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 at age forty-five (45) and older as follows: High-sensitivity guaiac fecal occult blood test (HSgFOBT) or fecal immunochemical test (FIT) every year; tool DNA-FIT every 1 to 3 years; Computed tomography colonography every 5 years; Flexible sigmoidoscopy every 5 years; Flexible sigmoidoscopy every 10 years + annual FIT; and Colonoscopy screening every 10 years.
4. Prostate cancer screening for men age 50 and older.

For more information on USPSTF, HRSA, ACIP and CDC, visit:
https://fbhealthplans.com/plans/individual-family-plans/core-choice/

*OFFICE COPAYMENT GUIDELINES

Copayments 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/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.

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 a 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."