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.

NEBRASKA FARM BUREAU® HEALTH PLANS TELADOC®

This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. Nebraska 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	$2,250 for individual $3,750 for individual $4,500 for family $7,500 for 2-person/3-person/family	$2,250 for individual $3,750 for individual $4,500 for family $7,500 for 2-person/3-person/family
OUT OF POCKET MAXIMUM (OOP)[2] • Family OOP maximum can be satisfied by one or more covered members during a calendar year • Once the OOP maximum is met, eligible benefits are provided at 100% for the remainder of the calendar year • Applies to eligible in-network provider services only	$4,500 for $2,250 deductible $5,625 for $3,750 deductible $9,000 for $4,500 deductible $11,250 for $7,500 deductible	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[9]	**Plan Pays**	**Your Responsibility**	**Plan Pays**	**Your Responsibility**
• Generic and Brand Prescriptions	80%	20%	60%	40%
• Unlimited calendar year maximum per member				
• Home Delivery Services are available				

TELADOC

Member must pay 100% of current Teladoc consultation fee until CYD is met. Once CYD is met, no consultation fee for Teladoc.

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 a member under the age of 7 (on plan deductibles $4,500 and $7,500) 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 ten years for members age 45 and older 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 member's physician. One baseline routine mammogram will be allowed for members between the ages of 35-39. One routine mammogram will be allowed annually for members 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 a member'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 a member 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."