ADVANCED CHOICE

Schedule of Benefits for Individuals and 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.

HEALTH PLANS

Teladoc HEALTH

This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. Ohio 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 CYD

$1,500 Per Individual
$3,000 Per Individual

	In-Network	Out-of-Network
OUT-OF-POCKET (OOP) MAXIMUM • 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 the OOP and must still be paid after the OOP is met	$1,500 CYD: $5,000 Per Individual $1,500 CYD: $10,000 Per Family $3,000 CYD: $10,000 Per Individual $3,000 CYD: $20,000 Per Family	Unlimited

LIFETIME BENEFIT MAXIMUM — Unlimited

Services

	In-Network		Out-of-Network	
OFFICE VISIT (Not subject to CYD)	$1,500 CYD: $30 Copay* Per Visit $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)	**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[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 Copay	$4 Copay[5]	60%	40%
• Brand - Subject to deductible	80%	20%	60%	40%
• $7,500 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)

Benefits include eye exams, eyeglasses and contact lenses

- No waiting period
- Eye exams are covered at 100% once every calendar year, no dollar limit
- Eyeglass frames, lenses or 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

Benefits include 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 frames, lenses or contact lenses are covered once every calendar year at 100% up to a maximum of $100 per individual, not subject to deductible and coinsurance

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FOOTNOTES

1. Preventative health exam for adults and children, including associated services, are provided by a physician, either directly during the exam or through appropriate referrals 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. One routine colonoscopy every ten years for individuals age 45 and older
4. Prostate cancer screening for men age 50 and older
5. Prescription copayments do not apply toward deductibles or out-of-pocket maximums

*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 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 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 6 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."