

TOGETHER *We Thrive.*



ndfb
Health Plans 

Your Health, Our Commitment.
Comprehensive Health Coverage with a Caring Touch.



As a Farm Bureau member you also have access to our Farm Bureau Health Plans coverage, and can enjoy high quality health care at an affordable rate.



Health is about more than just physical well-being; it's about feeling supported by friends, family and a caring community. North Dakota Farm Bureau Health Plans is here to provide the health coverage you need at every stage of life.

TOGETHER
We Care.

Why Us? NDFB is your trusted partner and has been since 1942. We are dedicated to enhancing the quality of life for all North Dakotans. North Dakota Farm Bureau Health Plans are an extension of that trust, service and membership value.

We offer individual and family plans, child-only plans, plans for turning 26, and plans to assist in bridging the early retirement gap until you are Medicare-eligible at age 65. Our plans offer a wealth of choices that will ensure you get the *coverage that's just right for you.*

Questions about our plans?

 Email us at healthplans@ndfb.org

 Visit ndfbhealthplans.com

Under 65 years of age? North Dakota Farm Bureau Health Plans offers a broad range of individual and family plans designed to suit everyone's particular health coverage needs including:

- ✓ Level of coverage
- ✓ Deductible and premium amounts
- ✓ Out-of-pocket payments





Words to know:

Premium

The cost of belonging to the plan. Think of it as a gym membership. You pay every month whether you use the gym or not.

Deductible

The amount you must pay for eligible medical services before the plan starts to pay for covered benefits.

Copayment (Copay) or coinsurance

If you have a claim, this is your share of the cost of those claims. If it's a specific dollar amount, it's called a **copay**. If the figure is a percentage of the bill, it's called **coinsurance**.

Each plan below has different terms depending on whether you choose to use in-network or out-of-network providers.

The health plans require medical underwriting that may affect eligibility and rates. North Dakota Farm Bureau membership is required.

ADVANCED CHOICE

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

CLASSIC CHOICE

The Classic Choice plan is for individuals who are looking for preventative health, along with limited dental and vision benefits. Get the trifecta — health, dental and vision — in one health plan.

MAJOR MEDICAL

A 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

Our range of High Deductible Health Plans (HDHP) meet all federal requirements necessary to open a Health Savings Account (HSA).

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.



This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. North 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 Member, per calendar year - Unless otherwise indicated, all benefits are subject to the CYD		Option 1	\$1,500 per member	
		Option 2	\$3,000 per member	
OUT OF POCKET MAXIMUM (OOP) - Once the OOP maximum is met, eligible benefits are provided at 100% for a member 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	Unlimited
		For \$3,000 CYD: Option 2	\$10,000 for individual coverage \$20,000 for family coverage	
LIFETIME BENEFIT MAXIMUM			Unlimited	
Services				
In-Network			Out-of-Network	
OFFICE VISIT (Not subject to CYD)	Option 1 For \$1,500 CYD:	\$30 copayment* per visit	CYD/Coinsurance	
	Option 2 For \$3,000 CYD:	\$40 copayment* per visit		
TELADOC (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 - 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 Members

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 member 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 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, 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. One routine colonoscopy every ten years for members 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 co-payment 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. Co-payments will not be applied toward deductibles or out-of-pocket maximums.

Co-payments 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 members, 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. 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 a member has completed a waiting period of at least 6 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."

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.



This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. North 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 a member 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:		\$45 copayment* per visit	
	Option 2: For \$6,000 CYD:		\$45 copayment* per visit	
TELADOC Not subject to CYD			\$0 copayment per visit	
			No Coverage	
COINSURANCE (Based on the maximum allowable charges for eligible benefits)	Plan Pays	Your Responsibility	Plan Pays	Your Responsibility
	80%	20%	60%	40%
PREVENTATIVE CARE BENEFITS (No waiting period. In-network benefits not subject to CYD.)	Plan Pays	Your Responsibility	Plan Pays	Your Responsibility
	100%	0%	60%	40%
• 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
	All but copayment	\$4 copayment ⁵	60%	40%
• Generic - 30 day supply	80%	20%	60%	40%
• Brand - Subject to deductible				
• Unlimited Calendar Year Maximum Per Individual				
EMERGENCY ROOM SERVICES (Not resulting in admission)			\$300 Deductible per visit (In addition to CYD and Coinsurance)	

DENTAL- No waiting periods

Pediatric (Under Age 19)

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

Age 19 and Over

- \$45 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 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 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. One routine colonoscopy every ten years for members 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 co-payment 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 an out-of-network coinsurance percentage after deductible is met.

Co-payments 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 Members age nineteen (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. Co-payments will not be applied to the deductibles or basis of an out-of-network.

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 a member 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."

HIGH DEDUCTIBLE HEALTH PLAN

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.



This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. North 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	\$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 COVERAGE⁹	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."

MAJOR MEDICAL

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.



This is a comprehensive health coverage plan that includes hospitalization, medical and prescription benefits. North 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 a member for the remainder of the calendar year • This applies to in-network provider services only		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%	Not Covered	
• Routine Colonoscopy ⁴	80%	60%	40%
• Annual Routine PSA ⁵	80%	60%	40%
• Annual Routine OB/GYN Exam ⁶	80%	Not Covered	
• Annual Routine Pap Smear ⁷	80%	60%	40%
• Mammogram ⁸	80%	60%	40%
PRESCRIPTION DRUG COVERAGE			
Plan Pays	Your Responsibility	Plan Pays	Your Responsibility
• Generic - 30 day supply	All but copayment	60%	40%
• Brand	80%	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 a 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 seven 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. Benefits will be provided, subject to deductible and coinsurance, 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. Prescription copayment does not apply toward deductible or out-of-pocket maximum.

MATERNITY BENEFITS

Maternity Benefits will be available after a member'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 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."

Highlights: DentalVision, offered through Farm Bureau Health Plans, uses Delta Dental PPO Plus Premier and VSP Choice provider networks. Network payments are based on negotiated fees.

If an out-of-network provider is used, the member's liability will increase significantly.

Dental Benefits						
	0-12 Months		13-24 Months		25+ Months	
Maximum Payment per person per year	\$500		\$1,000		\$1,500	
Deductible (excludes diagnostic and preventive and orthodontic) per person per year	\$50/\$150		\$50/\$150		\$50/\$150	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Diagnostic and Preventive						
Diagnostic and Preventive Services - Exams, cleanings, fluoride, and space maintainers	100%	80%	100%	80%	100%	80%
Radiographs - X-rays						
Emergency Palliative Treatment - To temporarily relieve pain						
Brush Biopsy - To detect oral cancer	50%	40%	80%	60%	80%	60%
Covered Services:						
Minor Restorative Services - Simple extractions, fillings, stainless steel crowns and crown repair	50%	40%	80%	60%	80%	60%
Sealants (under age 16) - To prevent decay of permanent teeth						
Endodontic Services - Root canals						
Periodontic Services - To treat gum disease						
Complex Extractions and Surgical Services						
Implant Repair - Implant maintenance, repair, and removal						
Relines and Rebases - To partial or complete dentures						
Prostodontic Services - Fixed bridges, partial or complete dentures, bridge repair	25%	10%	25%	10%	50%	40%
Major Restorative Services - Major crowns, cast restorations, veneers (limited)						
Bleaching/Whitening	25%	10%	25%	10%	50%	40%
Orthodontics (all ages)	0%	0%	50%	40%	50%	40%
Orthodontics Lifetime Maximum	N/A		\$1,000		\$1,000	

Deductible is per person per calendar year up to \$150 maximum for family coverage.

Benefits levels are based upon number of months specific member is enrolled in coverage.

*** Available for ages 1 year to 99 years.**

When services are received from a non-participating dentist, the percentages in this column indicate the portion of Delta Dental's Premier Dentist Schedule (or the non-participating dentist fee) that will be paid for those services. This amount may be less than what the dentist charges or Delta Dental approves and the member will be responsible for that difference.

Your Coverage With a VSP Provider			
Vision Benefits	Description	Copay	Frequency
WellVision Exam	- Focuses on eyes and overall wellness - KidsCare: Children have two, fully covered WellVision exams, if needed	\$15	Every calendar year
Prescription Glasses		\$35	See frames and lenses
Frame	\$150 allowance for a wide selection of frames \$170 allowance for featured frame brands 20% savings on the amount over allowance - KidsCare: Frames for children are covered up to the plan allowance every calendar year	Included in prescription glasses copay	Every other calendar year
Lenses	- Single vision, lined bifocal and lined trifocal lenses - Polycarbonate lenses for dependent children - KidsCare: Additional lenses for children are fully covered when needed. Minimum prescription change required	Included in prescription glasses copay	Every calendar year
Lens Enhancements	- Standard progressive lenses - High index lenses	Covered in full	Every calendar year
	Premium progressive lenses	\$105	
	Custom progressive lenses	\$175	
	Average savings of 20-25% on other lens enhancements		
Contacts (instead of glasses)	\$150 allowance for contacts; copay does not apply - Contact lens exam (fitting and evaluation)	Up to \$60	Every calendar year
Diabetic Eyecare Plus Program	Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	\$20	As needed
Extra Services	Glasses and Sunglasses - Extra \$20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of last WellVision exam.		
	Retinal Screening No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision exam		
	Laser Vision Correction Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		
	Low Vision Services - Professional services and materials for severe visual problems not corrected with regular lenses. - Benefit maximum for all Low Vision Benefits of \$1,000 every two (2) calendar years. - Includes supplemental testing, evaluation, diagnosis, and prescription of vision aids where indicated. Covered in full using a network provider. Out-of-network provider maximum benefit up to \$125. - Supplemental Aids: Covered at 75% of cost		

VSP Provider Network: VSP Choice

Your Coverage With Out-of-Network Providers		
Exam		Up to \$45
Frames		Up to \$70
Contacts		Up to \$105
Lenses	Lined Trifocal	Up to \$65
	Progressive	Up to \$50
	Single Vision	Up to \$30
	Lined Bifocal	Up to \$50

Walmart:

While not a full participating provider within this plan, Walmart will file a claim for vision benefits on a member's behalf and accept assignment (payment) from VSP. The use of Walmart's eye care center may not result in the maximization of benefit in all cases. It will come close, offering a potential convenience for a member. When using Walmart as a provider, please ask the eye care associate for expected costs when the benefits are utilized.

Visit vsp.com for details about providers other than a VSP network provider. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and the DentalVision contract, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.



PLAN ENHANCEMENTS



TELADOC 24/7 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.
Teladoc.com | **1-800-teladoc**



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. Call **1-800-788-4863**, TTY 711 to place home delivery orders anytime.



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. Seventy percent of Talkspace members reach clinically-significant improvement in a matter of weeks. *Deductible and co-pays apply.

talkspace.com/connect



HOW TO APPLY

Once you've chosen a plan, to apply for coverage:

Click 

Visit ndfbhealthplans.com and follow the directions for completing and submitting an application.

Contact 

Contact us via email at healthplans@ndfb.org to be referred to the agent closest to you.

Note: Be detailed and complete when applying for coverage. When you fill out your application, be sure to answer all questions truthfully and completely. North Dakota Farm Bureau Health Plans may cancel your plan and refuse to pay any claims if you leave out information or falsify important information. Review your application carefully before you sign it to be sure all information has been recorded properly.

You will need your North Dakota Farm Bureau membership ID number to record on your application.

TOGETHER *We Care* for Your Health and Well-Being

NDFB already provides many health-related benefits to its members to complement NDFB Health Plans opportunities:

As a Farm Bureau® member, you and your family can access a **FREE Prescription Drug Card program**. Save up to 80% at more than 68,000 national and regional pharmacies. Create as many cards as you need for yourself, your family, and your employees (full-time, part-time, seasonal). All members are eligible to get pharmacy discounts through this program.

The program can supplement most health insurance plans, including Health Savings Accounts (HSA) and High Deductible Plans. It can also be used as a Medicare Part D supplement by providing discounts on non-covered drugs.

This program has “LOWEST PRICE” logic to guarantee that you pay the lowest price on your prescriptions (you pay the lower discount off the Average Wholesale Price, a discount calculated off MAC Pricing, or the Pharmacy Promotional/Retail price).



ndfb
Membership

Anyone who resides in North Dakota can become a member of North Dakota Farm Bureau. When you become a member, you support North Dakota agriculture and your local community. Our purpose is simple: agriculture advocacy, education, and member service. Your membership dollars support this by allowing us to provide educational programs, leadership opportunities, and much more. See more information on page 19.

Benefits continued:



NO MORE waiting rooms, deductibles, and contracts. No insurance is necessary!

KonnectMD is a non-insurance healthcare membership that offers anyone convenience by providing nationwide, 24/7 access to virtual urgent care, primary care, and behavioral health treatments. Even with insurance, you can use KonnectMD to save thousands by avoiding copays and deductibles for traditional healthcare needs.

Sign up and save an average of \$2700/year for traditional healthcare expenses. The future is impossible to predict. When the unexpected happens, you can rest assured knowing KonnectMD will be there.



NDFB has partnered with **Life Line Screening** to allow members to be screened for the risk of heart disease and stroke. Screenings are not only accurate but also conducted in neighborhoods like yours every day, do not require the removal of clothing, are convenient, and only take a little more than an hour of your time.

4 Vital Screenings for \$135

- Carotid Artery Ultrasound to screen for plaque buildup in the arteries that supply blood to the brain.
- Atrial Fibrillation to look for an irregular heartbeat.
- Peripheral Artery Disease to screen for plaque buildup in the arms and legs.
- Abdominal Aortic Aneurysm ultrasound to screen for an enlargement in the abdominal aorta, the largest blood vessel in the body.

NDFB members receive the Osteoporosis screening for FREE.

Find ways to
SAVE MONEY
with your

NDFB
Membership

ndfb



ndfb.org/benefits



Plan on Us

ndfbhealthplans.com

or email us at

healthplans@ndfb.org



Join our family today.
Scan here.

