Deductible Plans		
	In Network (You Pay)	**Out-of-Network[4] (You Pay)**
Option 1 Calendar Year Deductible (ded)	$300 Self Only / $600 Family	
Coinsurance (applies only to certain services)	20%	40%
Out-of-Pocket Max (includes ded; excludes copays)	$800 Self Only / $1,600 Family	$1,300 Self Only / $2,600 Family
Option 2 Calendar Year Deductible	$500 Self Only / $1,000 Family	
Coinsurance (applies only to certain services)	20%	40%
Out-of-Pocket Max (includes ded; excludes copays)	$1,250 Self Only / $2,500 Family	$2,000 Self Only / $4,000 Family
Option 3 Calendar Year Deductible	$1,000 Self Only / $2,000 Family	
Coinsurance (applies only to certain services)	20%	40%
Out-of-Pocket Max (includes ded; excludes copays)	$2,000 Self Only / $4,000 Family	$3,000 Self Only / $6,000 Family
Option 4 Calendar Year Deductible	$2,500 Self Only / $5,000 Family	
Coinsurance (applies only to certain services)	20%	40%
Out-of-Pocket Max (includes ded; excludes copays)	$3,500 Self Only / $7,000 Family	$4,500 Self Only / $9,000 Family
Dependent Children Covered	Dependent to Age 26	
Plan Lifetime Maximum	Unlimited	
Pre-existing Condition Waiting Period(prior coverage credit can reduce or eliminate)	12 months (excludes members under the age 19)	
Physician Office Visit (includes Chiropractic care)	$30 Copay	Deductible and Coinsurance
Well Child Care Exams and Immunizations (through age 18)	Covered in Full	Deductible and Coinsurance
Adult Preventive Care[5]		
Adult Routine Physical Exam	Covered in Full	Deductible and Coinsurance
Routine GYN Exam & Pap Smear	Covered in Full	Deductible and Coinsurance
Routine Mammography	Covered in Full	Deductible and Coinsurance
Routine PSA Testing	Covered in Full	Deductible and Coinsurance
Routine Colonoscopy Screening	Covered in Full	Deductible and Coinsurance
Diagnostic Lab and X-ray	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital Services[1]	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Skilled Nursing Services[1,2]	Deductible and Coinsurance	Deductible and Coinsurance

This is a summary of benefits only and does not replace the legal contract or certificate which identifies all covered services, additional details, limitations and exclusions of the coverage.

[1] Pre-certification required. Human Organ and Tissue Transplant Services - services must be rendered at an approved Anthem transplant facility (In & Out of Network).
[2] Inpatient Skilled Nursing Care limited to 30 days per calendar year (In and Out of Network combined).
[3] Short-term therapies limited to 20-visit limit combined In & Out of Network.
[4] When utilizing the services of an Out-of-Network Anthem provider, patient will be responsible for the balance between the approved amount and provider's actual billed charges. Patient is paid directly and is responsible to reimburse the out-of-network provider.
[5] Benefits listed based on services rendered in a physicians office setting. This benefit is impacted by the Preventative Care requirements included in the Patient Protections and Affordable Care Act (PPACA). In accordance with the PPACA preventative care regulations, full coverage (no cost share) will be applied for those services meeting the requirements as outlined in Grade A and B Recommendations of the United States Preventative Services Task Force.

Farmers' Health Cooperative of Wisconsin — ASA Agri-Services Agency, Leaders in Agricultural Insurance — Anthem

Deductible Plans		
	In Network (You Pay)	**Out-of-Network[5] (You Pay)**
Outpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Room (Facility)	$100 Copay, waived if admitted	$100 Copay, waived if admitted
Urgent Care	$35 Copay	Deductible and Coinsurance
Ambulance	Deductible and Coinsurance	Deductible and 20% Coinsurance
Maternity Services **Inpatient Care**[1] (includes routine nursery charges) **Physician Care**	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Outpatient Chemotherapy	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Radiation Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Short-term Therapy Services[3] (Includes physical, speech and occupational therapies)	Deductible and Coinsurance	Deductible and Coinsurance
Mental Health - Inpatient[1] **Outpatient**	Deductible and Coinsurance $30 Copay	Deductible and Coinsurance Deductible and Coinsurance
Substance Abuse – Inpatient[1] **Outpatient**	Deductible and Coinsurance $30 Copay	Deductible and Coinsurance Deductible and Coinsurance
Surgical Care Including Office Surgery	Deductible and Coinsurance	Deductible and Coinsurance
Human Organ and Tissue Transplant Services[1]	Covered in Full	50% Coinsurance
Home Health Care (100 visits)	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Care	No Cost Share	No Cost Share
Diabetic Equipment and Supplies	Deductible and Coinsurance	Deductible and Coinsurance
Durable Medical Equipment	Deductible and Coinsurance	Deductible and Coinsurance
Prescription Medicines: **Retail** (30 day supply) Includes diabetic test strip	Tier 1 - $10 Copay Tier 2 - $30 Copay Tier 3 - $50 Copay	50%, minimum $50
Mail order (up to 90 day supply -1 copay per 30 day supply) Includes diabetic test strip Specialty medications are limited to a 30 day supply regardless of whether they are retail or mail service.	Tier 1 - $20 Copay Tier 2 - $60 Copay Tier 3 - $100 Copay	Not Covered

$2,000 Accident Policy included (underwritten by The Hartford). Up to $2,000 reimbursement for out-of-pocket medical expenses incurred as a result of an accident. This benefit is not applicable to illness.

Vision Benefit(underwritten by EyeMed Vision Care)
Annual Eye Exam: Participating Provider $5 copay- Non-Participating $30 Maximum Benefit
Eyewear: Participating Provider Only- frames, prescription lenses, and contact lenses available at discounted prices.

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