

<i>SERFF Tracking Number:</i>	<i>FEMC-126469728</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Federated Mutual Insurance Company</i>	<i>State Tracking Number:</i>	<i>44673</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H16G Group Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16G.001A Any Size Group - PPO</i>
<i>Product Name:</i>	<i>Group Health</i>		
<i>Project Name/Number:</i>	<i>SCH10/SCH10</i>		

## Filing at a Glance

Company: Federated Mutual Insurance Company

Product Name: Group Health

SERFF Tr Num: FEMC-126469728 State: Arkansas

TOI: H16G Group Health - Major Medical

SERFF Status: Closed-Approved-  
Closed State Tr Num: 44673

Sub-TOI: H16G.001A Any Size Group - PPO

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Author: Jeanette Myers

Disposition Date: 03/03/2010

Date Submitted: 01/25/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: SCH10

Status of Filing in Domicile: Pending

Project Number: SCH10

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Discretionary, Trust

Filing Status Changed: 03/03/2010

Explanation for Other Group Market Type:

State Status Changed: 03/08/2010

Deemer Date:

Created By: Jeanette Myers

Submitted By: Jeanette Myers

Corresponding Filing Tracking Number:

PPACA: Pre-PPACA Submission

Filing Description:

Federated Mutual Insurance Company is submitting six schedule of benefits forms. These schedules will replace previously approved forms. The revisions are:

1. Copayments will apply to office visits, urgent care office visits and emergency care services related to mental illness and chemical dependency. This was excluded on the previous versions of the schedules.
2. Transplant Services travel and lodging expenses has changed from "Additional \$5,000 for travel and lodging expenses available for transplants done through United Resource Network (URN)" to "Additional \$5,000 for travel and lodging expenses available for transplants done through a transplant network provider at a location more than 150 miles from the covered person's residence."

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3. For employers with more than 50 employees, chemical dependency benefits are paid the same as any other illness to comply with recent federal health parity legislation.

We are also submitting the following riders:

GH 03 80 (01-10 ed.) This is a revised rider which amends the definition of dependent in the policy and certificate and replaces a previously approved rider. The rider provides for continued coverage when an insured student is on a medically necessary leave of absence due to an illness or injury. Coverage can be continued for 1 year from the date the leave of absence began.

GH 00 90 (01-10 ed.) - this is a new rider that provides for the same schedule changes listed above for a plan that includes copayments.

GH 00 91 (01-10 ed.) - this is a new rider that provides for the same schedule changes listed above for a plan that does not include copayments.

All the forms submitted will be used in conjunction with group health certificate form GH 00 11 (01-02 ed.) approved by your department on 6/20/2002 and form GH 03 11 (08-06 ed.) approved on 5/23/2006.

The following is a list of forms being replaced by previously approved forms:

GH 03 20-FHC2 (01-10 ed.) will replace GH 03 20 (08-06 ed.) approved on 8/29/2006 under SERFF Tracking No. USPH-6SJK3E876.

GH 03 21-FHC2 (01-10 ed.) will replace GH 03 21 (08-06 ed.) approved on 8/29/2006 under SERFF Tracking No. USPH-6SJK3E876.

GH 00 23-FHC2 (01-10 ed.) will replace GH 00 23 (08-06 ed.) approved on 5/23/2006 under SERFF Tracking No. USPH-6NQPMC843.

GH 00 28.1-FHC2 (01-10 ed.) will replace GH 00 28.1 (01-09 ed.) approved on 10/9/2008 under state tracking no. 40486.

GH 00 28.2-FHC2 (01-10 ed.) will replace GH 00 28.2 (01-09 ed.) approved on 10/9/2008 under state tracking no. 40486.

GH 00 28.3-FHC2 (01-10 ed.) will replace GH 00 28.3 (01-09 ed.) approved on 10/9/2008 under state tracking no. 40486.

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*Project Name/Number:* SCH10/SCH10

GH 030 80 (01-10 ed.) will replace GH 030 80 (01-09 ed.) approved on 10/9/2008 under state tracking no. 40486.

## Company and Contact

### Filing Contact Information

Jeanette Myers, Compliance Analyst      jmmyers@fedins.com  
 121 East Park Square      800-533-0472 [Phone]  
 Owatonna, MN 55060      507-455-8226 [FAX]

### Filing Company Information

Federated Mutual Insurance Company	CoCode: 13935	State of Domicile: Minnesota
121 East Park Square	Group Code: 7	Company Type:
PO Box 328	Group Name:	State ID Number:
Owatonna, MN 55060	FEIN Number: 41-0417460	
(800) 533-0472 ext. [Phone]		

## Filing Fees

Fee Required?      Yes  
 Fee Amount:      \$125.00  
 Retaliatory?      Yes  
 Fee Explanation:      MN filing fee is \$125.  
 Per Company:      No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Federated Mutual Insurance Company	\$125.00	01/25/2010	33751148

SERFF Tracking Number: FEMC-126469728 State: Arkansas  
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 Product Name: Group Health  
 Project Name/Number: SCH10/SCH10

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/03/2010	03/03/2010
Approved-Closed	Rosalind Minor	02/10/2010	02/10/2010

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	01/28/2010	01/28/2010	Jeanette Myers	02/10/2010	02/10/2010

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Schedule of Benefits	Jeanette Myers	03/02/2010	03/02/2010

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Re-open closed filing.	Note To Reviewer	Jeanette Myers	03/01/2010	03/01/2010

*SERFF Tracking Number:* FEMC-126469728      *State:* Arkansas  
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*Project Name/Number:* SCH10/SCH10

## **Disposition**

Disposition Date: 03/03/2010

Implementation Date:

Status: Approved-Closed

Comment:

This submission has been re-opened in order for your to submit a revised Form: GH 00 23-FHC@(02-10 ed.). The revised form is being approved effective on this date.

The remainder of the submission will remain approved effective 2/10/10.

Rate data does NOT apply to filing.

SERFF Tracking Number: FEMC-126469728 State: Arkansas  
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 Company Tracking Number:  
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO  
 Product Name: Group Health  
 Project Name/Number: SCH10/SCH10

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Certification	Approved-Closed	Yes
Supporting Document	Actuarial Memorandum	Approved-Closed	No
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form (revised)	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Replaced	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes

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*Product Name:* Group Health  
*Project Name/Number:* SCH10/SCH10

## **Disposition**

Disposition Date: 02/10/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: FEMC-126469728 State: Arkansas  
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 Company Tracking Number:  
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Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Certification	Approved-Closed	Yes
Supporting Document	Actuarial Memorandum	Approved-Closed	No
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form (revised)	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Replaced	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes

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Project Name/Number: SCH10/SCH10

## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 01/28/2010

Submitted Date 01/28/2010

Respond By Date

Dear Jeanette Myers,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Schedule of Benefits, GH 03 20-FHC2 (01-10 ed.) (Form)
- Schedule of Benefits, GH 00 23-FHC2 (01-10 ed.) (Form)

### Comment:

I need further verification on some of the benefits that are paid the PPO & Non-PPO. I noticed that under the Supporting Documents, that there is a certification that benefits payable will comply with our Bulletin 9-85 which states in part that there will be no more than a 25% differential in payment between a PPO and Non-PPO.

Some of the benefits appear to have the potential of not being in compliance. For example:

Form GH 03 20-FHC2 (01-10.) - The Coinsurance - Metal Illness and Chemical Dependency and for other covered services are: (0% - 10%) for PPO and (20%-40%) for Non-PPO. There is a potential here for a choice of 10% PPO & 40% Non-PPO which would not be in compliance.

On Form GH 00 23-FHC2(01-10 ed.) - The Out of Pocket Maximum for Family Coverage is as follows: (\$6,800 - \$10,000) for PPO and (13,600 - \$21,000) for Non-PPO. If a choice is made for \$10,000 PPO and \$21,000 for Non-PPO, this amount also would not be in compliance.

Please offer further explanation/certification.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Product Name: Group Health  
Project Name/Number: SCH10/SCH10

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 02/10/2010  
Submitted Date 02/10/2010

Dear Rosalind Minor,

### Comments:

### Response 1

Comments: I'm attaching an actuarial memorandum that demonstrates that our plans do not exceed the 25% differential between benefits for preferred providers and non-preferred providers.

### Related Objection 1

Applies To:

- Schedule of Benefits, GH 03 20-FHC2 (01-10 ed.) (Form)
- Schedule of Benefits, GH 00 23-FHC2 (01-10 ed.) (Form)

Comment:

I need further verification on some of the benefits that are paid the PPO & Non-PPO. I noticed that under the Supporting Documents, that there is a certification that benefits payable will comply with our Bulletin 9-85 which states in part that there will be no more than a 25% differential in payment between a PPO and Non-PPO.

Some of the benefits appear to have the potential of not being in compliance. For example:

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Please offer further explanation/certification.

### Changed Items:

SERFF Tracking Number: FEMC-126469728 State: Arkansas  
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**Supporting Document Schedule Item Changes**

Satisfied -Name: Actuarial Memorandum

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

We respectfully request your further review of this filing for approval.

Sincerely,  
Jeanette Myers

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 Project Name/Number: SCH10/SCH10

**Amendment Letter**

Submitted Date: 03/02/2010

**Comments:**

Thank you for reopening this filing. I'm attaching a revised GH 00 23-FHC2 (02-10 ed.). The only change made to the form is on the last page - the Prescription Drug Benefits. Additional information has been added to clarify the benefit. The edition date has also been updated.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
GH 00 23-FHC2 (02-10 ed.)	Schedule Pages	Schedule of Benefits	Revised		USPH-6NQPMC84 3	GH 00 23 (08-06 ed.)		GH 00 23-FHC2 _02-10 ed_.pdf

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*Project Name/Number:* SCH10/SCH10

**Note To Reviewer**

**Created By:**

Jeanette Myers on 03/01/2010 11:02 AM

**Last Edited By:**

Jeanette Myers

**Submitted On:**

03/01/2010 11:02 AM

**Subject:**

Re-open closed filing.

**Comments:**

Ms Minor,

Would it be possible to re-open this closed filing to add a clarification to one of the schedules. We've had some misunderstandings about the drug coverage provided on our high deductible health plan and would like to add more information.

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 Project Name/Number: SCH10/SCH10

## Form Schedule

### Lead Form Number: GH 03 20-FHC2 (01-10 ed.)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/10/2010	GH 03 20-FHC2 (01-10 ed.)	Schedule Pages	Schedule of Benefits	Revised	Replaced Form #: GH 03 20 (08-06 ed.) Previous Filing #: USPH-6SJK3E876		GH 03 20-FHC2 _01-10 ed_.pdf
Approved-Closed 02/10/2010	GH 03 21-FHC2 (01-10 ed.)	Schedule Pages	Schedule of Benefits	Revised	Replaced Form #: GH 03 21 (08-06 ed.) Previous Filing #: USPH-6SJK3E876		GH 03 21-FHC2 _01-10 ed_.pdf
Approved-Closed 03/03/2010	GH 00 23-FHC2 (02-10 ed.)	Schedule Pages	Schedule of Benefits	Revised	Replaced Form #: GH 00 23 (08-06 ed.) Previous Filing #: USPH-6NQPMC843		GH 00 23-FHC2 _02-10 ed_.pdf
Approved-Closed 02/10/2010	GH 03 28.1-FHC2 (01-10 ed.)	Schedule Pages	Schedule of Benefits	Revised	Replaced Form #: GH 03 28.1 (01-09 ed.) Previous Filing #: 40486		GH 03 28.1-FHC2 _01-10 ed_.pdf
Approved-Closed 02/10/2010	GH 03 28.2-FHC2 (01-10 ed.)	Schedule Pages	Schedule of Benefits	Revised	Replaced Form #: GH 03 28.2 (01-09 ed.) Previous Filing #: 40486		GH 03 28.2-FHC2 _01-10 ed_.pdf
Approved-Closed 02/10/2010	GH 03 28.3-FHC2 (01-10 ed.)	Schedule Pages	Schedule of Benefits	Revised	Replaced Form #: GH 03 28.3 (01-09 ed.) Previous Filing #: 40486		GH 03 28.3-FHC2 _01-10 ed_.pdf
Approved-Closed	GH 03 80 (01-10 ed.)	Certificate Amendmen	Rider	Revised	Replaced Form #: GH 03 80 (01-09 ed.)		GH 03 80 _01-10

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<i>Product Name:</i>	<i>Group Health</i>		
<i>Project Name/Number:</i>	<i>SCH10/SCH10</i>		
02/10/2010	t, Insert Page, Endorseme nt or Rider	Previous Filing #: 40486	ed__.pdf
Approved- GH 00 90 Closed (01-10 ed.) 02/10/2010	Certificate Rider Amendmen t, Insert Page, Endorseme nt or Rider	Initial	GH 00 90- FHC1 _01-10 ed__.pdf
Approved- GH 00 91 Closed (01-10 ed.) 02/10/2010	Certificate Rider Amendmen t, Insert Page, Endorseme nt or Rider	Initial	GH 00 91- FHC1 _01-10 ed__.pdf

## SCHEDULE OF BENEFITS

Effective Date:

The **Schedule** of Benefits applies to residents of Arkansas.

Words and phrases appearing in **bold** type have special meaning as set forth in Section VIII - Definitions (form GH 00 08).

A. Payment of **benefits** for **covered expenses** are subject to the following:

	Network Provider	Non-Network Provider
<b>Deductible</b> Individual - other than <b>Prescription Drugs</b> subject to <b>copayments</b> .	[None - \$5,000]	[None - \$5,000]
<b>Deductible</b> Family - other than <b>Prescription Drugs</b> subject to <b>copayments</b> .	[None - \$10,000]	[None - \$10,000]
<b>Deductible</b> <b>Prescription Drugs</b> subject to <b>copayment</b> .	[None - \$500]	[None - \$500]
<b>Coinsurance - Mental Illness and Chemical Dependency</b>	[0% - 10%]	[20% - 40%]
<b>Coinsurance - other covered services</b>	[0% - 10%]	[20% - 40%]
<b>Copayment - physician office visit</b> charge	[\$20 - \$30]	Not applicable
<b>Copayment - urgent care office visit</b> charge	[\$20 - \$30]	Not applicable
<b>Copayment - emergency care</b> services	[\$100]	Not applicable
<b>Out-of-Pocket Maximum</b> Individual	[\$1,500 - \$7,000]	[\$3,500 - \$9,000]
<b>Out-of-Pocket Maximum</b> Family	[\$3,000 - \$14,000]	[\$7,000 - \$18,000]
<b>Lifetime Maximum</b>	[\$3,000,000] Combined for all <b>providers</b> .	

**Copayments** do not apply toward satisfying the **deductible**, **coinsurance** or **out-of-pocket maximum** requirements of the **policy**.

**Emergency care** services **copayment** is waived if the **covered person** is admitted to a **hospital** within 24 hours of the **emergency care visit**.

See Page 1 for **Copayment, Deductible** and **Coinsurance** amounts.

B. **Benefits** for **covered expenses** will be paid as follows. Refer to Section VI - **Covered Services** (form GH 00 06) for details of what services are covered.

<b>Covered Services</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Hospital Services</b> <b>Inpatient</b> <b>Outpatient</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Pre-certification is required for the following <b>surgeries</b> : abdominoplasty; blepharoplasty; breast augmentation or reduction; jaw <b>surgeries</b> ; nasal <b>surgeries</b> ; scar revisions; all varicose vein <b>surgery</b> or treatment; all laparoscopic procedures and all other <b>inpatient admissions</b> .	
Professional Services - <b>Surgery</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Pre-certification is required for the following <b>surgeries</b> : abdominoplasty; blepharoplasty; breast augmentation or reduction; jaw <b>surgeries</b> ; nasal <b>surgeries</b> ; scar revision; all varicose vein <b>surgery</b> or treatment; all laparoscopic procedures and all other <b>inpatient surgeries</b> .	
Professional Services - <b>Physician Services</b> <b>Office Visit Charge</b> <b>Urgent Care Office Visit Charge</b>	<b>Copayment</b>	<b>Deductible</b> <b>Copayment</b>
Professional Services - <b>Physician services</b> All Other Charges	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Anesthesia Services	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Radiology, Pathology, Laboratory and other Diagnostic Services <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Pre-certification is required for the following tests: CAT scan; MRI; PET scan; sleep studies.	
<b>Manipulative Therapy</b>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Maximum <b>benefit</b> of \$500 per <b>calendar year</b> for both <b>network providers</b> and <b>non-network providers</b> combined	
Dental Services	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Therapy <b>Physical Therapy</b> <b>Occupational Therapy</b> <b>Speech Therapy</b> Intravenous Therapy <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Nursing Facility Services</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Maximum of 60 days per confinement with a total of 60 days per <b>illness</b> or <b>injury</b> .	
Rehabilitative Services <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Dialysis Services	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>

See Page 1 for **Copayment, Deductible** and **Coinsurance** amounts.

<b>Covered Services</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
Elective Sterilizations	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>
Nutrition Counseling	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>
Diabetes Services	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>
Mastectomy <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>
Wellness Care Services Well Child Care	Birth up to age 18 - Services paid at 100%	Birth up to age 18 - services paid at 100% for immunization services. Other services up to age 7 - <b>Coinsurance</b> only Other services age 7 up to age 18 - <b>Deductible Coinsurance</b>
Wellness Care Services Annual Physical - Adult	Services paid at 100% <b>Benefit</b> limited to [\$500] per <b>calendar year</b> .	<b>Deductible Coinsurance</b> <b>Benefits</b> limited to [\$250] per <b>calendar year</b> .
Wellness Care Services Well Adult Care Diphtheria/Tetanus Immunization Cholesterol Screening Bone Mass Measurement	Services paid at 100%	<b>Deductible Coinsurance</b>
Wellness Care Services Cancer Screenings	Services paid at 100%	<b>Deductible Coinsurance</b>
Maternity Services <i>PRE-CERTIFICATION REQUIRED FOR HOSPITAL STAYS OVER THE MINIMUM COVERAGE</i>	<b>Copayment</b> for office visit <b>Deductible Coinsurance</b> for all other services	<b>Deductible Coinsurance</b>
Musculoskeletal Disorders <i>PRE-CERTIFICATION REQUIRED FOR SURGERY</i>	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>
Ambulance Services	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>
<b>Reconstructive Surgery</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>
<b>Medical Supplies</b> , oxygen and other gases	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>
<b>Emergency Care</b> Services	<b>Copayment</b> then <b>Coinsurance</b>	<b>Deductible Coinsurance</b>  For an <b>emergency condition</b> , the <b>network provider copayment</b> and <b>coinsurance</b> apply.

See Page 1 for **Copayment, Deductible** and **Coinsurance** amounts.

<b>Covered Services</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Durable Medical Equipment</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Prosthetic Devices</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Orthotic Devices</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Home Health Care Services</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Coverage limited to 100 visits per <b>calendar year</b> for <b>network</b> and <b>non-network providers</b> combined.	
<b>Hospice Care Services</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Transplant Services</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Copayment for office visit</b> <b>Deductible</b> <b>Coinsurance</b> for all other services	<b>Deductible</b> <b>Coinsurance</b>
	Additional [\$5,000] for travel and lodging expenses available for transplants done through a transplant <b>network provider</b> at a location more than 150 miles from the <b>covered person's</b> residence.	
<b>Mental Illness Services</b> <b>Chemical Dependency Services</b> <i>PRE-CERTIFICATION REQUIRED FOR INPATIENT AND TRANSITIONAL TREATMENT</i>	<b>Copayment for office visit and urgent care office visit</b> <b>Deductible</b> <b>Coinsurance</b> for all other services	<b>Deductible</b> <b>Coinsurance</b>
	For <b>mental illness</b> and <b>chemical dependency</b> services combined, maximum <b>benefit</b> of [\$2,500] per <b>calendar year</b> for <b>outpatient</b> services and [\$50,000] per <b>calendar year</b> for <b>inpatient</b> and transitional treatment combined. <b>Lifetime maximum</b> of [\$100,000] for all <b>mental illness</b> and <b>chemical dependency</b> services.  These sublimits do not apply to <b>serious mental illness</b> .  If the <b>employer</b> has more than 50 <b>employees</b> , these sublimits do not apply.	
<b>Contraceptive Devices</b>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>

See Page 1 for **Deductible** amount.

<b>Covered Services</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Prescription Drugs</b> - generic	<b>Deductible</b> then <b>Copayment</b> of [\$10 / 31] day supply <sup>1</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$10 / 31] day supply <sup>1</sup> plus the amount charged in excess of the <b>network</b> cost of the drug
<b>Prescription Drugs</b> - brand name on Performance Drug List	<b>Deductible</b> then <b>Copayment</b> of [\$30 / 31] day supply <sup>1</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$30 / 31] day supply <sup>1</sup> plus the amount charged in excess of the <b>network</b> cost of the drug
<b>Prescription Drugs</b> - brand name not on Performance Drug List <sup>2</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$45 / 31] day supply <sup>1, 2</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$45 / 31] day supply <sup>1</sup> plus the amount charged in excess of the <b>network</b> cost of the drug <sup>2</sup>
<b>Prescription Drugs</b> - on Specialty Drug List <sup>3</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$45 / 31] day supply <sup>1</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$45 / 31] day supply <sup>1</sup> plus the amount charged in excess of the <b>network</b> cost of the drug
<b>Prescription Drugs</b> - mail order - generic	<b>Deductible</b> then <b>Copayment</b> of [\$20 / 90] day supply	Not available
<b>Prescription Drugs</b> - mail order - brand name on Performance Drug List	<b>Deductible</b> then <b>Copayment</b> of [\$60 / 90] day supply	Not available
<b>Prescription Drugs</b> - mail order - brand name not on Performance Drug List <sup>2</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$100 / 90] day supply <sup>2</sup>	Not available
<b>Prescription Drugs</b> - Inpatient or hospital provided or in a <b>physician's</b> office other than drugs on the Specialty Drug List	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>

**Copayments** will apply to **Prescription Drugs** dispensed at a contracting mail order or retail pharmacy that agrees in writing to the same terms and conditions that apply to the contractual agreement offered to any contracting mail order pharmacy.

Generic drugs are the pharmaceutical equivalent to a brand name drug and are identical in strength, concentration and dosage.

Brand name drugs have the trademarked name of the drug on the package label.

Performance drug list is a list of generic and brand name drugs designated for use as performance drugs. The list is subject to periodic review and modification.

<sup>1</sup> Maximum dispensing limits have been set on some **prescription drugs**. Consult pharmacy for details.

<sup>2</sup> If a generic drug or performance drug does not exist or a **physician** prescribes a brand name drug when medically necessary, the brand name drug **copayment** will apply. If the **covered person** requests a brand name drug when a generic drug is available, he will pay the generic drug **copayment** plus the difference in cost between the brand name drug and the generic drug.

<sup>3</sup> Specialty drug list is a list of drugs designated as specialty drugs available through **our** specialty drug program. The list is subject to periodic review and modification. Specialty drugs obtained from sources other than **our** specialty drug program are subject to **non-network copayments** even if obtained through a **provider** that is part of another contracted network.

**Copayments** do not apply toward satisfying the **deductible, coinsurance** or **out-of-pocket maximum** requirements of the **policy**. The **deductible** for **prescription drugs** subject to **copayment**, does not apply toward satisfying the **out-of-pocket maximum** requirements of the **policy**.

## SCHEDULE OF BENEFITS

Effective Date:

The **Schedule** of Benefits applies to residents of Arkansas.

Words and phrases appearing in **bold** type have special meaning as set forth in Section VIII - Definitions (form GH 00 08).

A. Payment of **benefits** for **covered expenses** are subject to the following:

	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Deductible</b> Individual - other than <b>Prescription Drugs</b> subject to <b>copayments</b> .	[None - \$10,000]	[None - \$10,000]
<b>Deductible</b> Family - other than <b>Prescription Drugs</b> subject to <b>copayments</b> .	[\$2,000 - \$20,000]	[\$2,000 - \$20,000]
<b>Deductible</b> <b>Prescription Drugs</b> subject to <b>copayment</b> .	[None - \$500]	[None - \$500]
<b>Coinsurance - Mental Illness and Chemical Dependency</b>	[0% - 20%]	[20% - 40%]
<b>Coinsurance - other covered services</b>	[0% - 20%]	[20% - 40%]
<b>Out-of-Pocket Maximum</b> Individual	[\$1,000 - \$10,000]	[\$3,000 - \$14,000]
<b>Out-of-Pocket Maximum</b> Family	[\$2,000 - \$20,000]	[\$6,000 - \$28,000]
<b>Lifetime Maximum</b>	[\$3,000,000] Combined for all <b>providers</b> .	

See Page 1 for **Deductible** and **Coinsurance** amounts.

B. **Benefits** for **covered expenses** will be paid as follows. Refer to Section VI - **Covered Services** (form GH 00 06) for details of what services are covered.

<b>Covered Expenses</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Hospital Services</b> <b>Inpatient</b> <b>Outpatient</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Pre-certification is required for the following <b>surgeries</b> : abdominoplasty; blepharoplasty; breast augmentation or reduction; jaw <b>surgeries</b> ; nasal <b>surgeries</b> ; scar revision; all varicose vein <b>surgery</b> or treatment; all laparoscopic procedures and all other <b>inpatient admissions</b> .	
Professional Services - <b>Surgery</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Pre-certification is required for the following <b>surgeries</b> : abdominoplasty; blepharoplasty; breast augmentation or reduction; jaw <b>surgeries</b> ; nasal <b>surgeries</b> ; scar revision; all varicose vein <b>surgery</b> or treatment; all laparoscopic procedures and all other <b>inpatient surgeries</b> .	
Professional Services - <b>Physician Services</b>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Anesthesia Services	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Radiology, Pathology, Laboratory and other Diagnostic Services <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Pre-certification is required for the following tests: CAT scan; MRI; PET scan; sleep studies.	
<b>Manipulative Therapy</b>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Maximum <b>benefit</b> of [\$500] per <b>calendar year</b> for both <b>network providers</b> and <b>non-network</b> providers combined	
Dental Services	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Therapy <b>Physical Therapy</b> <b>Occupational Therapy</b> <b>Speech Therapy</b> Intravenous Therapy <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Nursing Facility Services</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Maximum of 60 days per confinement with a total of 60 days per <b>illness or injury</b> .	
Rehabilitative Services <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Dialysis Services	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>

See Page 1 for **Deductible** and **Coinsurance** amounts.

<b>Covered Services</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
Elective Sterilizations	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>
Nutrition Counseling	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>
Diabetes Services	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>
Mastectomy <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>
Wellness Care Services Well Child Care	Birth up to age 18 - Services paid at 100%	Birth up to age 18 - Services paid at 100% for immunization services. Other services up to age 7 - <b>Coinsurance</b> only Other services age 7 up to age 18 - <b>Deductible Coinsurance</b>
Wellness Care Services Annual Physical - Adult	Services paid at 100% <b>Benefit</b> limited to [\$500] per <b>calendar year</b> .	<b>Deductible Coinsurance</b> <b>Benefit</b> limited to [\$250] per <b>calendar year</b> .
Wellness Care Services Well Adult Care  Diphtheria/Tetanus Immunization Cholesterol Screening Bone Mass Measurement	Services paid at 100%	<b>Deductible Coinsurance</b>
Wellness Care Services Cancer Screenings	Services paid at 100%	<b>Deductible Coinsurance</b>
Maternity Services <i>PRE-CERTIFICATION REQUIRED FOR HOSPITAL STAYS OVER THE MINIMUM COVERAGE</i>	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>
Musculoskeletal Disorders <i>PRE-CERTIFICATION REQUIRED FOR SURGERY</i>	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>
Ambulance Services	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>
<b>Reconstructive Surgery</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>
<b>Medical Supplies</b> , oxygen and other gases	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>
<b>Emergency Care</b> Services	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>  For an <b>emergency condition</b> , the <b>network provider deductible</b> and <b>coinsurance</b> apply.

See Page 1 for **Deductible** and **Coinsurance** amount.

<b>Covered Services</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Durable Medical Equipment</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Prosthetic Devices</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Orthotic Devices</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Home Health Care Services</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Coverage limited to 100 visits per <b>calendar year</b> for <b>network</b> and <b>non-network providers</b> combined.	
<b>Hospice Care Services</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Transplant Services <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Additional [\$5,000] for travel and lodging expenses available for transplants done through a transplant <b>network provider</b> at a location more than 150 miles from the <b>covered person's</b> residence.	
<b>Mental Illness Services</b> <b>Chemical Dependency Services</b> <i>PRE-CERTIFICATION REQUIRED FOR INPATIENT AND TRANSITIONAL TREATMENT</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	For <b>mental illness</b> and <b>chemical dependency</b> services combined, maximum <b>benefit</b> of [\$2,500] per <b>calendar year</b> for <b>outpatient</b> services and [\$50,000] per <b>calendar year</b> for <b>inpatient</b> and transitional treatment combined. <b>Lifetime maximum</b> of [\$100,000] for all <b>mental illness</b> and <b>chemical dependency</b> services.	
	These sublimits do not apply to <b>serious mental illness</b> . If the <b>employer</b> has more than 50 <b>employees</b> , these sublimits do not apply.	
Contraceptive Devices	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>

See Page 1 for **Deductible** amount.

<b>Covered Services</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Prescription Drugs</b> - generic	<b>Deductible</b> then <b>Copayment</b> of [\$10 / 31] day supply <sup>1</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$10 / 31] day supply <sup>1</sup> plus the amount charged in excess of the <b>network</b> cost of the drug
<b>Prescription Drugs</b> - brand name on Performance Drug List	<b>Deductible</b> then <b>Copayment</b> of [\$30 / 31] day supply <sup>1</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$30 / 31] day supply <sup>1</sup> plus the amount charged in excess of the <b>network</b> cost of the drug
<b>Prescription Drugs</b> - brand name not on Performance Drug List <sup>2</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$45 / 31] day supply <sup>1, 2</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$45 / 31] day supply <sup>1</sup> plus the amount charged in excess of the <b>network</b> cost of the drug <sup>2</sup>
<b>Prescription Drugs</b> - on Specialty Drug List <sup>3</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$45 / 31] day supply <sup>1</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$45 / 31] day supply <sup>1</sup> plus the amount charged in excess of the <b>network</b> cost of the drug
<b>Prescription Drugs</b> - mail order - generic	<b>Deductible</b> then <b>Copayment</b> of [\$20 / 90] day supply	Not available
<b>Prescription Drugs</b> - mail order - brand name on Performance Drug List	<b>Deductible</b> then <b>Copayment</b> of [\$60 / 90] day supply	Not available
<b>Prescription Drugs</b> - mail order - brand name not on Performance Drug List <sup>2</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$100 / 90] day supply <sup>2</sup>	Not available
<b>Prescription Drugs</b> - Inpatient or hospital provided or in a <b>physician's</b> office other than drugs on the Specialty Drug List	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>

**Copayments** will apply to **Prescription Drugs** dispensed at a contracting mail order or retail pharmacy that agrees in writing to the same terms and conditions that apply to the contractual agreement offered to any contracting mail order pharmacy.

Generic drugs are the pharmaceutical equivalent to a brand name drug and are identical in strength, concentration and dosage.

Brand name drugs have the trademarked name of the drug on the package label.

Performance drug list is a list of generic and brand name drugs designated for use as performance drugs. The list is subject to periodic review and modification.

<sup>1</sup> Maximum dispensing limits have been set on some **prescription drugs**. Consult pharmacy for details.

<sup>2</sup> If a generic drug or performance drug does not exist or a **physician** prescribes a brand name drug when medically necessary, the brand name drug **copayment** will apply. If the **covered person** requests a brand name drug when a generic drug is available, he will pay the generic drug **copayment** plus the difference in cost between the brand name drug and the generic drug.

<sup>3</sup> Specialty drug list is a list of drugs designated as specialty drugs available through **our** specialty drug program. The list is subject to periodic review and modification. Specialty drugs obtained from sources other than **our** specialty drug program are subject to **non-network copayments** even if obtained through a **provider** that is part of another contracted network.

**Copayments** do not apply toward satisfying the **deductible**, **coinsurance** or **out-of-pocket maximum** requirements of the **policy**. The **deductible** for **prescription drugs** subject to **copayment**, does not apply toward satisfying the **out-of-pocket maximum** requirements of the **policy**.

**SCHEDULE OF BENEFITS**

Effective Date:

The **Schedule** of Benefits applies to residents of the following states: [Arkansas.]

This health care plan may be used in conjunction with a Health Savings Account (HSA).

Words and phrases appearing in **bold** type have special meaning as set forth in Section VIII - Definitions (form GH 00 08).

A. Payment of **benefits** for **covered expenses** are subject to the following:

	<b>Network Provider</b>	<b>Non-Network Provider</b>
<u>Employee Only Coverage</u>		
<b>Deductible</b>	[\$2,400 - \$5,000]	[\$2,400 - \$5,000]
<b>Out-of-Pocket Maximum</b>	[\$3,400 - \$5,000]	[\$6,800 - \$10,500]
<u>Family Coverage</u>		
<b>Deductible</b>	[\$4,800 - \$10,000]	[\$4,800 - \$10,000]
<b>Out-of-Pocket Maximum</b>	[\$6,800 - \$10,000]	[\$13,600 - \$21,000]
<b>Coinsurance</b>	[0% - 20%]	[25% - 45%]
<b>Lifetime Maximum</b>	[\$3,000,000] Combined for all <b>providers</b> .	

The **deductible** and **out-of-pocket maximums** are subject to annual cost of living adjustments based on the Consumer Price Index (CPI) published by the Department of Labor. For that reason, the **deductible** and **out-of-pocket maximums** may be adjusted annually.

See Page 1 for **Deductible** and **Coinsurance** amounts.

- B. **Benefits** for **covered expenses** will be paid as follows. Refer to Section VI - **Covered Services** (form GH 00 06) for details of what services are covered.

<b>Covered Services</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Hospital Services</b> <b>Inpatient</b> <b>Outpatient</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Pre-certification is required for the following <b>surgeries</b> : abdominoplasty; blepharoplasty; breast augmentation or reduction; jaw <b>surgeries</b> ; nasal <b>surgeries</b> ; scar revisions; all varicose vein <b>surgery</b> or treatment; all laparoscopic procedures and all other <b>inpatient admissions</b> .	
Professional Services - <b>Surgery</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Pre-certification is required for the following <b>surgeries</b> : abdominoplasty; blepharoplasty; breast augmentation or reduction; jaw <b>surgeries</b> ; nasal <b>surgeries</b> ; scar revisions; all varicose vein <b>surgery</b> or treatment; all laparoscopic procedures and all other <b>inpatient surgeries</b> .	
Professional Services - <b>Physician Services</b>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Anesthesia Services	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Radiology, Pathology, Laboratory and other Diagnostic Services <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Pre-certification is required for the following tests: CAT scan; MRI; PET scan; sleep studies.	
<b>Manipulative Therapy</b>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Maximum <b>benefit</b> of [\$500] per <b>calendar year</b> for both <b>network providers</b> and <b>non-network providers</b> combined.	
Dental Services	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Therapy <b>Physical Therapy</b> <b>Occupational Therapy</b> <b>Speech Therapy</b> Intravenous Therapy <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Nursing Facility Services</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Maximum of 60 days per confinement with a total of 60 days per <b>illness</b> or <b>injury</b>	
Rehabilitation Services <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Dialysis Services	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>

See Page 1 for **Deductible** and **Coinsurance** amounts.

<b>Covered Services</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
Elective Sterilizations	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Nutrition Counseling	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Diabetes Services	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Mastectomy <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Wellness Care Services Well Child Care	Birth up to age 18 - Services paid at 100%	Birth up to age 18 - Services paid at 100% for immunization services. Other services up to age 7 - <b>Coinsurance</b> only Other services age 7 up to age 18 - <b>Deductible</b> <b>Coinsurance</b>
Wellness Care Services Annual Physical - Adult	Services paid at 100% <b>Benefit</b> limited to [\$500] per <b>calendar year.</b>	<b>Deductible</b> <b>Coinsurance</b> <b>Benefit</b> limited to [\$250] per <b>calendar year.</b>
Wellness Care Services Well Adult Care  Diphtheria/Tetanus Immunization Cholesterol Screening Bone Mass Measurement	Services paid at 100%	<b>Deductible</b> <b>Coinsurance</b>
Wellness Care Services Cancer Screenings	Services paid at 100%	<b>Deductible</b> <b>Coinsurance</b>
Maternity Services <i>PRE-CERTIFICATION REQUIRED</i> <i>FOR HOSPITAL STAYS OVER THE</i> <i>MINIMUM COVERAGE</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Musculoskeletal Disorders <i>PRE-CERTIFICATION REQUIRED</i> <i>FOR SURGERY</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Ambulance Services	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Reconstructive Surgery</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Medical Supplies</b> , oxygen and other gases	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Emergency Care</b> Services	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b> For an <b>emergency condition</b> , the <b>network provider deductible</b> and <b>coinsurance</b> apply.

See Page 1 for **Deductible** and **Coinsurance** amounts.

<b>Covered Services</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Durable Medical Equipment</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Prosthetic Devices</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Orthotic Devices</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Home Health Care Services</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Coverage limited to 100 visits per <b>calendar year</b> for <b>network</b> and <b>non-network providers</b> combined.	
<b>Hospice Care Services</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Transplant Services</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Additional [\$5,000] for travel and lodging expenses available for transplants done through a transplant <b>network provider</b> at a location more than 150 miles from the <b>covered person's</b> residence.	
<b>Mental Illness Services</b> <b>Chemical Dependency Services</b> <i>PRE-CERTIFICATION REQUIRED</i> <i>FOR INPATIENT AND</i> <i>TRANSITIONAL TREATMENT</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	For <b>mental illness</b> and <b>chemical dependency</b> services combined, maximum <b>benefit</b> of [\$2,500] per <b>calendar year</b> for <b>outpatient</b> services and [\$50,000] per <b>calendar year</b> for <b>inpatient</b> and transitional treatment combined. <b>Lifetime maximum</b> of [\$100,000] for all <b>mental illness</b> and <b>chemical dependency</b> services.  These sublimits do not apply to <b>serious mental illness</b> .  If the <b>employer</b> has more than 50 <b>employees</b> , these sublimits do not apply.	
<b>Contraceptive Devices</b>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>

See Page 1 for **Deductible** and **Coinsurance** amounts.

<b>Covered Services</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Prescription Drugs</b> - generic or on Performance Drug List <sup>1</sup>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b> plus the amount charged in excess of the <b>network</b> cost of the drug.
<b>Prescription Drugs</b> - brand name not on Performance Drug List <sup>1, 2</sup>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b> plus the amount charged in excess of the <b>network</b> cost of the drug.
<b>Prescription Drugs</b> - on Specialty Drug List <sup>3</sup>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b> plus the amount charged in excess of the <b>network</b> cost of the drug.
<b>Prescription Drugs</b> - mail order - generic or on Performance Drug list. <sup>4</sup>	<b>Deductible</b> <b>Coinsurance</b>	Not available
<b>Prescription Drugs</b> - mail order - brand name not on Performance Drug list. <sup>2, 4</sup>	<b>Deductible</b> <b>Coinsurance</b>	Not available
<b>Prescription Drugs</b> - <b>Inpatient</b> or <b>hospital</b> provided or in a <b>physician's</b> office other than drugs on the Specialty Drug List.	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>

Generic drugs are the pharmaceutical equivalent to a brand name drug and are identical in strength, concentration and dosage.

Brand name drugs have the trademarked name of the drug on the package label.

Performance drug list is a list of generic and brand name drugs designated for use as performance drugs. The list is subject to periodic review and modification.

<sup>1</sup> Maximum dispensing limits of 31-day supply.

<sup>2</sup> If a **covered person** requests a brand name drug when a generic drug or Performance List drug is available, he will pay the difference in cost between the brand name drug and the generic drug.

<sup>3</sup> Specialty drug list is a list of drugs designated as specialty drugs available through **our** specialty drug program. The list is subject to periodic review and modification. Specialty drugs obtained from sources other than **our** specialty drug program are subject to **non-network deductible and coinsurance** even if obtained through a **provider** that is part of another contracted network.

<sup>4</sup> Maximum dispensing limit of 90-day supply.

## SCHEDULE OF BENEFITS

Effective Date:

The **Schedule** of Benefits applies to residents of Arkansas.

Words and phrases in **bold** type have special meaning as set forth in Section VIII - Definitions (form GH 00 08).

A. Payment of **benefits** for **covered expenses** is subject to the following

	Network Provider	Non-Network Provider
<b>Deductible</b> Individual - other than <b>prescription drugs</b> subject to <b>copayments</b> .	[\$300 - \$10,000]	[\$300 - \$10,000]
<b>Deductible</b> Family - other than <b>prescription drugs</b> subject to <b>copayments</b> .	[\$600 - \$20,000]	[\$600 - \$20,000]
<b>Deductible</b> <b>Prescription drugs</b> subject to <b>copayment</b> .	[None - \$500]	[None - \$500]
<b>Coinsurance - mental illness or chemical dependency</b>	[20%]	[40% - 45%]
<b>Coinsurance - other covered services</b>	[20%]	[40% - 45%]
<b>Out-of-Pocket Maximum - Individual</b>	[\$2,300 - \$12,000]	[\$4,300 - \$14,500]
<b>Out-of-Pocket Maximum - Family</b>	[\$4,600 - \$24,000]	[\$8,600 - \$29,000]
<b>Lifetime Maximum</b>	[\$3,000,000 Combined for all <b>providers</b> .]	

See Section A. for **Deductible** and **Coinsurance** amounts.

B. **Benefits** for **covered expenses** will be paid as follows. Refer to Section VI - **Covered Services** (form GH 00 06) for details of what services are covered.

Covered Services	Network Provider	Non-Network Provider
Services received while an <b>inpatient</b> . Limits may apply to <b>mental illness</b> and <b>chemical dependency</b> services. (See page 2.)	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Services received as part of an <b>office visit</b> or <b>urgent care</b> visit for other than wellness care services or <b>prescription drugs</b> .	<b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Maximum <b>benefit</b> of [\$500] per <b>calendar year</b> for both <b>network providers</b> and <b>non-network providers</b> combined for <b>manipulative therapy</b> .	
Services received as part of an <b>emergency care visit</b> (not including ambulance services) for other than <b>prescription drugs</b> .	<b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b> For an <b>emergency condition</b> , <b>emergency care</b> services are paid at <b>network provider coinsurance</b> .
All other <b>covered services</b> , treatments or supplies (including <b>durable medical equipment</b> ) for other than wellness care services or <b>prescription drugs</b> . Limits may apply to <b>mental illness</b> and <b>chemical dependency</b> services. (See page 2.)	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Additional [\$5,000] for travel and lodging expenses available for transplants done through a transplant <b>network provider</b> at a location more than 150 miles from the <b>covered person's</b> residence.	

See Section A. for **Deductible** and **Coinsurance** amounts.

<b>Covered Services</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
Wellness Care Services Well Child Care	Birth up to age 18 - Services paid at 100%	Birth up to age 18 - Services paid at 100% for immunization services. Other services up to age 7 - <b>Coinsurance</b> only Other services age 7 up to age 18 - <b>Deductible</b> <b>Coinsurance</b>
Wellness Care Services Annual Physical - Adult	Services paid at 100% <b>Benefit</b> limited to [\$500] per <b>calendar year</b> .	<b>Deductible</b> <b>Coinsurance</b> <b>Benefit</b> limited to [\$250] per <b>calendar year</b> .
Wellness Care Services Well Adult Care  Diphtheria/Tetanus Immunization Cholesterol Screening Bone Mass Measurement Cancer Screenings	Services paid at 100%	<b>Deductible</b> <b>Coinsurance</b>
<b>Mental Illness Services</b> <b>Chemical Dependency Services</b> <i>PRE-CERTIFICATION REQUIRED FOR INPATIENT AND TRANSITIONAL TREATMENT</i>	<b>Coinsurance</b> for <b>office visit</b> or <b>urgent care visit</b> or <b>emergency care visit</b> .  <b>Deductible</b> <b>Coinsurance</b> for all other services	<b>Deductible</b> <b>Coinsurance</b>
	For <b>mental illness</b> and <b>chemical dependency</b> services combined, maximum <b>benefit</b> of [\$2,500] per <b>calendar year</b> for <b>outpatient</b> services and [\$50,000] per <b>calendar year</b> for <b>inpatient</b> and transitional treatment combined. <b>Lifetime maximum</b> of [\$100,000] for all <b>mental illness</b> and <b>chemical dependency</b> services.  These sublimits do not apply to <b>serious mental illness</b> .  If the <b>employer</b> has more than 50 <b>employees</b> , these sublimits do not apply.	
PRE-CERTIFICATION REQUIRED FOR: All <b>inpatient</b> services. <b>Nursing facility</b> services; hospice care services; <b>home health care</b> services; transplant services; and rehabilitative services. <b>Durable medical equipment; prosthetic devices; and orthotic devices;</b> <b>Surgeries:</b> abdominoplasty; blepharoplasty; breast augmentation or reduction; jaw <b>surgeries</b> ; nasal <b>surgeries</b> ; scar revision; all varicose vein <b>surgery</b> or treatment; <b>reconstructive surgeries</b> ; musculoskeletal <b>surgeries</b> ; all laparoscopic procedures and all other <b>inpatient surgeries</b> . Tests: CAT scan; MRI; PET scan; and sleep studies. Therapies: <b>speech therapy; occupational therapy; physical therapy;</b> and intravenous therapy. <b>Mental illness or chemical dependency: inpatient or transitional treatment.</b>		

See Section A. for **Deductible** amount.

Covered Services	Network Provider	Non-Network Provider
Prescription Drugs - generic	Deductible then Copayment of [\$10 / 31] day supply <sup>1</sup>	Deductible then Copayment of [\$10 / 31] day supply <sup>1</sup> plus the amount charged in excess of the <b>network</b> cost of the drug
Prescription Drugs - brand name on Performance Drug List	Deductible then Copayment of [\$30 / 31] day supply <sup>1</sup>	Deductible then Copayment of [\$30 / 31] day supply plus the amount charged in excess of the <b>network</b> cost of the drug
Prescription Drugs - brand name not on Performance Drug List <sup>2</sup>	Deductible then Copayment of [\$45 / 31] day supply <sup>1, 2</sup>	Deductible then Copayment of [\$45 / 31] day supply <sup>1</sup> plus the amount charged in excess of the <b>network</b> cost of the drug <sup>2</sup>
Prescription Drugs - on Specialty Drug List <sup>3</sup>	Deductible then Copayment of [\$45 / 31] day supply <sup>1</sup>	Deductible then Copayment of [\$45 / 31] day supply <sup>1</sup> plus the amount charged in excess of the <b>network</b> cost of the drug
Prescription Drugs - mail order - generic	Deductible then Copayment of [\$20 / 90] day supply	Not available
Prescription Drugs - mail order - brand name on Performance Drug List	Deductible then Copayment of [\$60 / 90] day supply	Not available
Prescription Drugs - mail order - brand name not on Performance Drug List <sup>2</sup>	Deductible then Copayment of [\$100 / 90] day supply <sup>2</sup>	Not available
Prescription Drugs - Inpatient or hospital provided or in a physician's office other than drugs on the Specialty Drug List	Deductible Coinsurance	Deductible Coinsurance

Copayments will apply to Prescription Drugs dispensed at a contracting mail order or retail pharmacy that agrees in writing to the same terms and conditions that apply to the contractual agreement offered to any contracting mail order pharmacy.

Generic drugs are the pharmaceutical equivalent to a brand name drug and are identical in strength, concentration and dosage.

Brand name drugs have the trademarked name of the drug on the package label.

Performance drug list is a list of generic and brand name drugs designated for use as performance drugs. The list is subject to periodic review and modification.

<sup>1</sup> Maximum dispensing limits have been set on some **prescription drugs**. Consult pharmacy for details.

<sup>2</sup> If a generic drug or performance drug does not exist or a **physician** prescribes a brand name drug when medically necessary, the brand name drug **copayment** will apply. If the **covered person** requests a brand name drug when a generic drug is available, he will pay the generic drug **copayment** plus the difference in cost between the brand name drug and the generic drug.

<sup>3</sup> Specialty drug list is a list of drugs designated as specialty drugs available through **our** specialty drug program. The list is subject to periodic review and modification. Specialty drugs obtained from sources other than **our** specialty drug program are subject to **non-network copayments** even if obtained through a **provider** that is part of another contracted network.

**Copayments** do not apply toward satisfying the **deductible**, **coinsurance** or **out-of-pocket maximum** requirements of the **policy**. The **deductible** for **prescription drugs** subject to **copayment**, does not apply toward satisfying the **out-of-pocket maximum** requirements of the **policy**.

## SCHEDULE OF BENEFITS

Effective Date:

The **Schedule** of Benefits applies to residents of Arkansas.

Words and phrases in **bold** type have special meaning as set forth in Section VIII - Definitions (form GH 00 08).

A. Payment of **benefits** for **covered expenses** is subject to the following:

	Network Provider	Non-Network Provider
<b>Deductible</b> Individual - other than <b>prescription drugs</b> subject to <b>copayments</b> .	[\$300 - \$10,000]	[\$300 - \$10,000]
<b>Deductible</b> Family - other than <b>prescription drugs</b> subject to <b>copayments</b> .	[\$600 - \$20,000]	[\$600 - \$20,000]
<b>Deductible</b> <b>Prescription Drugs</b> subject to <b>copayment</b> .	[None - \$1,000]	[None - \$1,000]
<b>Coinsurance - mental illness or chemical dependency</b>	[30%]	[40% - 50%]
<b>Coinsurance - Option A</b>	[30%]	[40% - 50%]
<b>Coinsurance - Option B</b>	[20%]	[40% - 50%]
<b>Out-of-Pocket Maximum - Individual</b>	[\$2,300 - \$12,000]	[\$4,300 - \$14,500]
<b>Out-of-Pocket Maximum - Family</b>	[\$4,600 - \$24,000]	[\$8,600 - \$29,000]
<b>Lifetime Maximum</b>	[\$3,000,000 Combined for all <b>providers</b> .]	

See Section A. for **Deductible** and **Coinsurance** amounts.

B. **Benefits** for **covered expenses** will be paid as follows. Refer to Section VI - **Covered Services** (form GH 00 06) for details of what services are covered.

Covered Services	Network Provider	Non-Network Provider
Services received while an <b>inpatient</b> . Limits may apply to <b>mental illness</b> and <b>chemical dependency</b> services. (See page 2)	<b>Deductible</b> <b>Coinsurance - Option A</b>	<b>Deductible</b> <b>Coinsurance</b>
Services received as part of an <b>office visit</b> or <b>urgent care</b> visit for other than wellness care services or <b>prescription drugs</b> .	<b>Coinsurance - Option B</b>	<b>Deductible</b> <b>Coinsurance</b>
	Maximum <b>benefit</b> of [\$500] per <b>calendar year</b> for both <b>network providers</b> and <b>non-network providers</b> combined for <b>manipulative therapy</b> .	
Services received as part of an <b>emergency care visit</b> (not including ambulance services) for other than <b>prescription drugs</b> .	<b>Coinsurance - Option A</b>	<b>Deductible</b> <b>Coinsurance</b>  For an <b>emergency condition</b> , <b>emergency care</b> services are paid at <b>network provider coinsurance</b> .
All other <b>covered services</b> , treatments or supplies (including <b>durable medical equipment</b> ) for other than wellness care services or <b>prescription drugs</b> . Limits may apply to <b>mental illness</b> and <b>chemical dependency</b> services. (See page 2)	<b>Deductible</b> <b>Coinsurance - Option A</b>	<b>Deductible</b> <b>Coinsurance</b>
	Additional [\$5,000] for travel and lodging expenses available for transplants done through a transplant <b>network provider</b> at a location more than 150 miles from the <b>covered person's</b> residence.	

See Section A. for **Deductible** and **Coinsurance** amounts.

<b>Covered Services</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
Wellness Care Services Well Child Care	Birth up to age 18 - Services paid at 100%	Birth up to age 18 - Services paid at 100% for immunization services. Other services up to age 7 - <b>Coinsurance</b> only Other services age 7 up to age 18 - <b>Deductible</b> <b>Coinsurance</b>
Wellness Care Services Annual Physical - Adult	Services paid at 100% <b>Benefit</b> limited to [\$500] per <b>calendar year</b> .	<b>Deductible</b> <b>Coinsurance</b> <b>Benefit</b> limited to [\$250] per <b>calendar year</b> .
Wellness Care Services Well Adult Care  Diphtheria/Tetanus Immunization Cholesterol Screening Bone Mass Measurement Cancer Screenings	Services paid at 100%	<b>Deductible</b> <b>Coinsurance</b>
<b>Mental Illness</b> Services <b>Chemical Dependency</b> Services <i>PRE-CERTIFICATION REQUIRED FOR INPATIENT AND TRANSITIONAL TREATMENT</i>	<b>Coinsurance</b> - Option B for <b>office visit</b> or <b>urgent care visit</b> .  <b>Coinsurance</b> - Option A for <b>emergency care visit</b> .  <b>Deductible</b> <b>Coinsurance</b> - Option A for all other services	<b>Deductible</b> <b>Coinsurance</b>
	For <b>mental illness</b> and <b>chemical dependency</b> services combined, maximum <b>benefit</b> of [\$2,500] per <b>calendar year</b> for <b>outpatient</b> services and [\$50,000] per <b>calendar year</b> for <b>inpatient</b> and transitional treatment combined. <b>Lifetime maximum</b> of [\$100,000] for all <b>mental illness</b> and <b>chemical dependency</b> services.  These sublimits do not apply to <b>serious mental illness</b> .  If the <b>employer</b> has more than 50 <b>employees</b> , these sublimits do not apply.	
PRE-CERTIFICATION REQUIRED FOR:  All <b>inpatient</b> services.  <b>Nursing facility</b> services; hospice care services; <b>home health care</b> services; transplant services; and rehabilitative services.  <b>Durable medical equipment; prosthetic devices; and orthotic devices.</b>  <b>Surgeries:</b> abdominoplasty; blepharoplasty; breast augmentation or reduction; jaw <b>surgeries</b> ; nasal <b>surgeries</b> ; scar revision; all varicose vein <b>surgery</b> or treatment; <b>reconstructive surgeries</b> ; musculoskeletal <b>surgeries</b> ; all laparoscopic procedures and all other <b>inpatient surgeries</b> .  Tests: CAT scan; MRI; PET scan; and sleep studies.  Therapies: <b>speech therapy; occupational therapy; physical therapy;</b> and intravenous therapy.  <b>Mental illness or chemical dependency: inpatient or transitional treatment.</b>		

See Section A. for **Deductible** amount.

Covered Services	Network Provider	Non-Network Provider
<b>Prescription Drugs</b> - generic	<b>Deductible</b> then <b>Copayment</b> of [\$10 / 31] day supply <sup>1</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$10 / 31] day supply <sup>1</sup> plus the amount charged in excess of the <b>network</b> cost of the drug
<b>Prescription Drugs</b> - brand name on Performance Drug List	<b>Deductible</b> then <b>Copayment</b> of [\$30 / 31] day supply <sup>1</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$30 / 31] day supply <sup>1</sup> plus the amount charged in excess of the <b>network</b> cost of the drug
<b>Prescription Drugs</b> - brand name not on Performance Drug List <sup>2</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$45 / 31] day supply <sup>1, 2</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$45 / 31] day supply <sup>1</sup> plus the amount charged in excess of the <b>network</b> cost of the drug <sup>2</sup>
<b>Prescription Drugs</b> - on Specialty Drug List <sup>3</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$45 / 31] day supply <sup>1</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$45 / 31] day supply <sup>1</sup> plus the amount charged in excess of the <b>network</b> cost of the drug
<b>Prescription Drugs</b> - mail order - generic	<b>Deductible</b> then <b>Copayment</b> of [\$20 / 90] day supply	Not available
<b>Prescription Drugs</b> - mail order - brand name on Performance Drug List	<b>Deductible</b> then <b>Copayment</b> of [\$60 / 90] day supply	Not available
<b>Prescription Drugs</b> - mail order - brand name not on Performance Drug List <sup>2</sup>	<b>Deductible</b> then <b>Copayment</b> of [\$100 / 90] day supply <sup>2</sup>	Not available
<b>Prescription Drugs</b> - Inpatient or hospital provided or in a physician's office other than drugs on the Specialty Drug List	<b>Deductible Coinsurance</b> - Option A	<b>Deductible Coinsurance</b>

**Copayments** will apply to **Prescription Drugs** dispensed at a contracting mail order or retail pharmacy that agrees in writing to the same terms and conditions that apply to the contractual agreement offered to any contracting mail order pharmacy.

Generic drugs are the pharmaceutical equivalent to a brand name drug and are identical in strength, concentration and dosage.

Brand name drugs have the trademarked name of the drug on the package label.

Performance drug list is a list of generic and brand name drugs designated for use as performance drugs. The list is subject to periodic review and modification.

<sup>1</sup> Maximum dispensing limits have been set on some **prescription drugs**. Consult pharmacy for details.

<sup>2</sup> If a generic drug or performance drug does not exist or a **physician** prescribes a brand name drug when medically necessary, the brand name drug **copayment** will apply. If the **covered person** requests a brand name drug when a generic drug is available, he will pay the generic drug **copayment** plus the difference in cost between the brand name drug and the generic drug.

<sup>3</sup> Specialty drug list is a list of drugs designated as specialty drugs available through **our** specialty drug program. The list is subject to periodic review and modification. Specialty drugs obtained from sources other than **our** specialty drug program are subject to **non-network copayments** even if obtained through a **provider** that is part of another contracted network.

**Copayments** do not apply toward satisfying the **deductible**, **coinsurance** or **out-of-pocket maximum** requirements of the **policy**. The **deductible** for **prescription drugs** subject to **copayment**, does not apply toward satisfying the **out-of-pocket maximum** requirements of the **policy**.

## SCHEDULE OF BENEFITS

Effective Date:

The **Schedule** of Benefits applies to residents of Arkansas.

Words and phrases in **bold** type have special meaning as set forth in Section VIII - Definitions (form GH 00 08).

A. Payment of **benefits** for **covered expenses** is subject to the following:

	Network Provider	Non-Network Provider
<b>Deductible</b> Individual - other than <b>prescription drugs</b> subject to <b>copayments</b> .	[\$1,000 - \$10,000]	[\$1,000 - \$10,000]
<b>Deductible</b> Family - other than <b>prescription drugs</b> subject to <b>copayments</b> .	[\$2,000 - \$20,000]	[\$2,000 - \$20,000]
<b>Deductible</b> <b>Prescription drugs</b> subject to <b>copayment</b> .	[None - \$1,000]	[None - \$1,000]
<b>Coinsurance - mental illness or chemical dependency</b>	[0%]	[30%]
<b>Coinsurance - other covered services</b>	[0%]	[30%]
<b>Out-of-Pocket Maximum - Individual</b>	[\$2,000 - \$11,000]	[\$4,000 - \$13,000]
<b>Out-of-Pocket Maximum - Family</b>	[\$4,000 - \$22,000]	[\$8,000 - \$26,000]
<b>Lifetime Maximum</b>	[\$3,000,000 Combined for all <b>providers</b> .]	

See Section A. for **Deductible** and **Coinsurance** amounts.

B. **Benefits** for **covered expenses** will be paid as follows. Refer to Section VI - **Covered Services** (form GH 00 06) for details of what services are covered.

Covered Services	Network Provider	Non-Network Provider
Services received while an <b>inpatient</b> . Limits may apply to <b>mental illness</b> and <b>chemical dependency</b> services. (See page 2)	<b>Deductible</b>	<b>Deductible</b> <b>Coinsurance</b>
Services received as part of an <b>office visit</b> or <b>urgent care</b> visit for other than wellness care services or <b>prescription drugs</b> .	<b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Maximum <b>benefit</b> of [\$500] per <b>calendar year</b> for both <b>network providers</b> and <b>non-network providers</b> combined for <b>manipulative therapy</b> .	
Services received as part of an <b>emergency care visit</b> (not including ambulance services) for other than <b>prescription drugs</b> .	<b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>  For an <b>emergency condition</b> , <b>emergency care</b> services are paid at <b>network provider coinsurance</b> .
All other <b>covered services</b> , treatments or supplies (including <b>durable medical equipment</b> ) for other than wellness care services or <b>prescription drugs</b> . Limits may apply to <b>mental illness</b> and <b>chemical dependency</b> services. (See page 2)	<b>Deductible</b>	<b>Deductible</b> <b>Coinsurance</b>
	Additional [\$5,000] for travel and lodging expenses available for transplants done through a transplant <b>network provider</b> at a location more than 150 miles from the <b>covered person's</b> residence.	

See Section A. for **Deductible** and **Coinsurance** amounts.

<b>Covered Services</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
Wellness Care Services Well Child Care	Birth up to age 18 - Services paid at 100%	Birth up to age 18 - Services paid at 100% for immunization services. Other services up to age 7 - <b>Coinsurance</b> only Other services age 7 up to age 18 - <b>Deductible</b> <b>Coinsurance</b>
Wellness Care Services Annual Physical - Adult	Services paid at 100% <b>Benefit</b> limited to [\$500] per <b>calendar year</b> .	<b>Deductible</b> <b>Coinsurance</b> <b>Benefit</b> limited to [\$250] per <b>calendar year</b> .
Wellness Care Services Well Adult Care  Diphtheria/Tetanus Immunization Cholesterol Screening Bone Mass Measurement Cancer Screenings	Services paid at 100%	<b>Deductible</b> <b>Coinsurance</b>
<b>Mental Illness</b> Services <b>Chemical Dependency</b> Services <i>PRE-CERTIFICATION REQUIRED FOR INPATIENT AND TRANSITIONAL TREATMENT</i>	<b>Coinsurance</b> for <b>office visit</b> or <b>urgent care visit</b> or <b>emergency care visit</b> .  <b>Deductible</b> for all other services	<b>Deductible</b> <b>Coinsurance</b>
	For <b>mental illness</b> and <b>chemical dependency</b> services combined, maximum <b>benefit</b> of [\$2,500] per <b>calendar year</b> for <b>outpatient</b> services and [\$50,000] per <b>calendar year</b> for <b>inpatient</b> and transitional treatment combined. <b>Lifetime maximum</b> of [\$100,000] for all <b>mental illness</b> and <b>chemical dependency</b> services.  These sublimits do not apply to <b>serious mental illness</b> .  If the <b>employer</b> has more than 50 <b>employees</b> , these sublimits do not apply.	
PRE-CERTIFICATION REQUIRED FOR:  All <b>inpatient</b> services.  <b>Nursing facility</b> services; hospice care services; <b>home health care</b> services; transplant services; and rehabilitative services.  <b>Durable medical equipment; prosthetic devices; and orthotic devices.</b>  <b>Surgeries:</b> abdominoplasty; blepharoplasty; breast augmentation or reduction; jaw <b>surgeries</b> ; nasal <b>surgeries</b> ; scar revision; all varicose vein <b>surgery</b> or treatment; <b>reconstructive surgeries</b> ; musculoskeletal <b>surgeries</b> ; all laparoscopic procedures and all other <b>inpatient surgeries</b> .  Tests: CAT scan; MRI; PET scan; and sleep studies.  Therapies: <b>speech therapy; occupational therapy; physical therapy;</b> and intravenous therapy.  <b>Mental illness or chemical dependency: inpatient</b> or transitional treatment.		

See Section A. for **Deductible** amount.

Covered Services	Network Provider	Non-Network Provider
Prescription Drugs - generic	Deductible then Copayment of [\$10 / 31] day supply <sup>1</sup>	Deductible then Copayment of [\$10 / 31] day supply <sup>1</sup> plus the amount charged in excess of the <b>network</b> cost of the drug
Prescription Drugs - brand name on Performance Drug List	Deductible then Copayment of [\$30 / 31] day supply <sup>1</sup>	Deductible then Copayment of [\$30 / 31] day supply <sup>1</sup> plus the amount charged in excess of the <b>network</b> cost of the drug
Prescription Drugs - brand name not on Performance Drug List <sup>2</sup>	Deductible then Copayment of [\$45 / 31] day supply <sup>1, 2</sup>	Deductible then Copayment of [\$45 / 31] day supply <sup>1</sup> plus the amount charged in excess of the <b>network</b> cost of the drug <sup>2</sup>
Prescription Drugs - on Specialty Drug List <sup>3</sup>	Deductible then Copayment of [\$45 / 31] day supply <sup>1</sup>	Deductible then Copayment of [\$45 / 31] day supply <sup>1</sup> plus the amount charged in excess of the <b>network</b> cost of the drug
Prescription Drugs - mail order - generic	Deductible then Copayment of [\$20 / 90] day supply	Not available
Prescription Drugs - mail order - brand name on Performance Drug List	Deductible then Copayment of [\$60 / 90] day supply	Not available
Prescription Drugs - mail order - brand name not on Performance Drug List <sup>2</sup>	Deductible then Copayment of [\$100 / 90] day supply <sup>2</sup>	Not available
Prescription Drugs - Inpatient or hospital provided or in a physician's office other than drugs on the Specialty Drug List	Deductible Coinsurance	Deductible Coinsurance

**Copayments** will apply to **Prescription Drugs** dispensed at a contracting mail order or retail pharmacy that agrees in writing to the same terms and conditions that apply to the contractual agreement offered to any contracting mail order pharmacy.

Generic drugs are the pharmaceutical equivalent to a brand name drug and are identical in strength, concentration and dosage.

Brand name drugs have the trademarked name of the drug on the package label.

Performance drug list is a list of generic and brand name drugs designated for use as performance drugs. The list is subject to periodic review and modification.

<sup>1</sup> Maximum dispensing limits have been set on some **prescription drugs**. Consult pharmacy for details.

<sup>2</sup> If a generic drug or performance drug does not exist or a **physician** prescribes a brand name drug when medically necessary, the brand name drug **copayment** will apply. If the **covered person** requests a brand name drug when a generic drug is available, he will pay the generic drug **copayment** plus the difference in cost between the brand name drug and the generic drug.

<sup>3</sup> Specialty drug list is a list of drugs designated as specialty drugs available through **our** specialty drug program. The list is subject to periodic review and modification. Specialty drugs obtained from sources other than **our** specialty drug program are subject to **non-network copayments** even if obtained through a **provider** that is part of another contracted network.

**Copayments** do not apply toward satisfying the **deductible, coinsurance** or **out-of-pocket maximum** requirements of the policy. The **deductible** for **prescription drugs** subject to **copayment**, does not apply toward satisfying the **out-of-pocket maximum** requirements of the **policy**.

**FEDERATED MUTUAL  
INSURANCE COMPANY**  
HOME OFFICE: 121 East Park Square, Owatonna, Minnesota 55060

**GROUP HEALTH POLICY AND CERTIFICATE RIDER**

**POLICY NUMBER:** [0000]  
**RIDER EFFECTIVE DATE:** [January 1, 2010]

The **policy** and certificate are changed as follows for residents of Arkansas:

Section VIII - Definitions, 29. **Dependent** or **Dependents**, is deleted and replaced with the following:

29. **Dependent** or **Dependents**

means the person shown below. A person who is a **covered employee** is not eligible as a **dependent** under any **policy** issued by **us**. No one can be considered a **dependent** of more than one **covered employee** under any **policy** issued by **us**. If both **spouses** are covered as **covered employees** under any **policy** issued by **us**, only one **spouse** shall be considered to have any eligible **dependents**.

- a. **Spouse.** This is a **covered employee's** current legal **spouse**.
- b. **Child.** This is a **covered employee's**:
  - i. unmarried natural or legally adopted child;
  - ii. unmarried child for whom the **covered employee** or his **spouse** is the legal guardian;
  - iii. unmarried step-child living with the **covered employee**; or
  - iv. a child covered under a valid qualified medical child support order (as the term is defined under Section 609 of the Employee Retirement Income Security Act (ERISA) and its implementing regulations) which is enforceable against a **covered employee**.

In each case the child must be unmarried and less than 25 years old or a disabled **dependent**, as described below. Coverage is available to the end of the **calendar year** in which the child marries or reaches the age of 25. Coverage will also be available beyond age 25 for an unmarried child who is a student in an accredited institution of postsecondary education as long as full-time student status is maintained or the child is on a **medically necessary** leave of absence from school due to serious **illness or injury**. Continued coverage during a **medically necessary** leave of absence from school is limited to 1 year from the date the leave of absence began.

- c. Disabled **Dependent**. This is a **covered employee's** child who is beyond the limiting age and physically handicapped or mentally disabled, and obtains the majority of his financial support from the **covered employee**. The disability must have come into existence prior to age 25. Disability does not include pregnancy. "Disabled" means incapable of self-sustaining employment by reason of mental retardation, **mental illness**, or physical handicap. At **our** request and **our** expense, the **covered employee** must give **us** proof of the **dependent's** disability. We reserve the right to periodically review the disability. After the first two years, we will not review the disability more frequently than once every **calendar year**.

PRESIDENT

SECRETARY

**FEDERATED MUTUAL  
INSURANCE COMPANY**  
HOME OFFICE: 121 East Park Square, Owatonna, Minnesota 55060

**GROUP HEALTH POLICY AND CERTIFICATE RIDER**

**POLICY NUMBER:** [0000]  
**RIDER EFFECTIVE DATE:** [January 1, 2010]

The **policy** and certificate are changed as follows for residents of [Arkansas]:

1. The Schedule of **Benefits** sections on Transplant Services, **Mental Illness** Services and **Chemical Dependency** Services are deleted and replaced with the following:

Transplant Services <i>PRE-CERTIFICATION REQUIRED</i>	<b>Copayment for office visit</b>	<b>Deductible Coinsurance</b>
	<b>Deductible Coinsurance</b> for all other services	
Additional [\$5,000] for travel and lodging expenses available for transplants done through a transplant <b>network provider</b> at a location more than 150 miles from the <b>covered person's</b> residence.		
Mental Illness Services Chemical Dependency Services <i>PRE-CERTIFICATION REQUIRED FOR INPATIENT AND TRANSITIONAL TREATMENT</i>	<b>Copayment for office visit or emergency care visits</b>	<b>Deductible Coinsurance</b>
	<b>Deductible Coinsurance</b> for all other services	
For <b>mental illness</b> and <b>chemical dependency</b> services combined, maximum <b>benefit</b> of [\$2,500] per <b>calendar year</b> for <b>outpatient</b> services and [\$50,000] per <b>calendar year</b> for <b>inpatient</b> and transitional treatment combined. <b>Lifetime maximum</b> of [\$100,000] for all <b>mental illness</b> and <b>chemical dependency</b> services.  These sublimits do not apply to <b>serious mental illness</b> .  If the <b>employer</b> has more than 50 <b>employees</b> , these sublimits do not apply.		

2. The following is deleted from Page 1 of the Schedule of **Benefits**: “**Copayments** do not apply to **office visits** or **emergency care visits** related to **mental illness** or **chemical dependency**.”

PRESIDENT

SECRETARY

**FEDERATED MUTUAL  
INSURANCE COMPANY**  
HOME OFFICE: 121 East Park Square, Owatonna, Minnesota 55060

**GROUP HEALTH POLICY AND CERTIFICATE RIDER**

**POLICY NUMBER:** [0000]  
**RIDER EFFECTIVE DATE:** [January 1, 2010]

The **policy** and certificate are changed as follows for residents of [Arkansas]:

1. The Schedule of **Benefits** sections on Transplant Services, **Mental Illness** Services and **Chemical Dependency** Services are deleted and replaced with the following:

Transplant Services <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>
Additional [\$5,000] for travel and lodging expenses available for transplants done through a transplant <b>network provider</b> at a location more than 150 miles from the <b>covered person's</b> residence.		
<b>Mental Illness</b> Services <b>Chemical Dependency</b> Services <i>PRE-CERTIFICATION REQUIRED FOR INPATIENT AND TRANSITIONAL TREATMENT</i>	<b>Deductible Coinsurance</b>	<b>Deductible Coinsurance</b>
For <b>mental illness</b> and <b>chemical dependency</b> services combined, maximum <b>benefit</b> of [\$2,500] per <b>calendar year</b> for <b>outpatient</b> services and [\$50,000] per <b>calendar year</b> for <b>inpatient</b> and transitional treatment combined. <b>Lifetime maximum</b> of [\$100,000] for all <b>mental illness</b> and <b>chemical dependency</b> services.  These sublimits do not apply to <b>serious mental illness</b> .  If the <b>employer</b> has more than 50 <b>employees</b> , these sublimits do not apply.		

PRESIDENT

SECRETARY

SERFF Tracking Number: FEMC-126469728 State: Arkansas  
 Filing Company: Federated Mutual Insurance Company State Tracking Number: 44673  
 Company Tracking Number:  
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO  
 Product Name: Group Health  
 Project Name/Number: SCH10/SCH10

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Flesch Certification	Approved-Closed	02/10/2010
<b>Comments:</b>			
<b>Attachment:</b>			
ARCERT.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Application	Approved-Closed	02/10/2010
<b>Bypass Reason:</b>	N/A		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Certification	Approved-Closed	02/10/2010
<b>Comments:</b>			
<b>Attachment:</b>			
AR_CERT.pdf			

FEDERATED MUTUAL INSURANCE COMPANY

Owatonna, Minnesota

January 25, 2010

CERTIFICATE OF COMPLIANCE

Arkansas

I hereby certify that Federated Mutual Insurance Company meets the provisions set forth in Rule and Regulation 19 as well as all applicable requirements of the Arkansas Department of Insurance.

---

Timothy G. Luy  
Vice President

STATE OF ARKANSAS  
CERTIFICATION OF COMPLIANCE

FEDERATED MUTUAL INSURANCE COMPANY

FORM TITLE(S): **Group Health Schedule of Benefits & Riders**

FORM NUMBER(S): GH 03 20-FHC2 (01-10 ed.), GH 03 21-FHC2 (01-10 ed.)  
GH 00 23-FHC2 (01-10 ed.), GH 03 28.1-FHC2 (01-10 ed.)  
GH 03 28.2-FHC2 (01-10 ed.), GH 03 28.3-FHC2 (01-10 ed.)  
GH 03 80 (01-10 ed.), GH 00 90-FHC1 (01-10 ed.)  
GH 00 91-FHC1 (01-10 ed.)

I hereby certify that Preferred Provider in-network and out-of-network benefit levels will not exceed a 25% differential for residents of Arkansas.

\_\_\_\_\_  
Signature of Officer

Timothy G. Luy  
\_\_\_\_\_  
Name

Vice President  
\_\_\_\_\_  
Title and/or Business Affiliation

January 25, 2010  
\_\_\_\_\_  
Date

SERFF Tracking Number: FEMC-126469728 State: Arkansas  
 Filing Company: Federated Mutual Insurance Company State Tracking Number: 44673  
 Company Tracking Number:  
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO  
 Product Name: Group Health  
 Project Name/Number: SCH10/SCH10

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/25/2010	Form	Schedule of Benefits	03/02/2010	GH 00 23-FHC2 _01-10 ed._.pdf (Superseded)

## SCHEDULE OF BENEFITS

Effective Date:

The **Schedule** of Benefits applies to residents of the following states: [Arkansas]

This health care plan may be used in conjunction with a Health Savings Account (HSA).

Words and phrases appearing in **bold** type have special meaning as set forth in Section VIII - Definitions (form GH 00 08).

A. Payment of **benefits** for **covered expenses** are subject to the following:

	Network Provider	Non-Network Provider
<u>Employee Only Coverage</u>		
<b>Deductible</b>	[\$2,400 - \$5,000]	[\$2,400 - \$5,000]
<b>Out-of-Pocket Maximum</b>	[\$3,400 - \$5,000]	[\$6,800 - \$10,500]
<u>Family Coverage</u>		
<b>Deductible</b>	[\$4,800 - \$10,000]	[\$4,800 - \$10,000]
<b>Out-of-Pocket Maximum</b>	[\$6,800 - \$10,000]	[\$13,600 - \$21,000]
<b>Coinsurance</b>	[0% - 20%]	[25% - 45%]
<b>Lifetime Maximum</b>	[\$3,000,000] Combined for all <b>providers</b> .	

The **deductible** and **out-of-pocket maximums** are subject to annual cost of living adjustments based on the Consumer Price Index (CPI) published by the Department of Labor. For that reason, the **deductible** and **out-of-pocket maximums** may be adjusted annually.

See Page 1 for **Deductible** and **Coinsurance** amounts.

- B. **Benefits** for **covered expenses** will be paid as follows. Refer to Section VI - **Covered Services** (form GH 00 06) for details of what services are covered.

<b>Covered Services</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Hospital Services</b> <b>Inpatient</b> <b>Outpatient</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Pre-certification is required for the following <b>surgeries</b> : abdominoplasty; blepharoplasty; breast augmentation or reduction; jaw <b>surgeries</b> ; nasal <b>surgeries</b> ; scar revisions; all varicose vein <b>surgery</b> or treatment; all laparoscopic procedures and all other <b>inpatient admissions</b> .	
Professional Services - <b>Surgery</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Pre-certification is required for the following <b>surgeries</b> : abdominoplasty; blepharoplasty; breast augmentation or reduction; jaw <b>surgeries</b> ; nasal <b>surgeries</b> ; scar revisions; all varicose vein <b>surgery</b> or treatment; all laparoscopic procedures and all other <b>inpatient surgeries</b> .	
Professional Services - <b>Physician Services</b>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Anesthesia Services	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Radiology, Pathology, Laboratory and other Diagnostic Services <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Pre-certification is required for the following tests: CAT scan; MRI; PET scan; sleep studies.	
<b>Manipulative Therapy</b>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Maximum <b>benefit</b> of [\$500] per <b>calendar year</b> for both <b>network providers</b> and <b>non-network providers</b> combined.	
Dental Services	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Therapy <b>Physical Therapy</b> <b>Occupational Therapy</b> <b>Speech Therapy</b> Intravenous Therapy <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Nursing Facility Services</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Maximum of 60 days per confinement with a total of 60 days per <b>illness</b> or <b>injury</b>	
Rehabilitation Services <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Dialysis Services	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>

See Page 1 for **Deductible** and **Coinsurance** amounts.

<b>Covered Services</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
Elective Sterilizations	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Nutrition Counseling	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Diabetes Services	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Mastectomy <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Wellness Care Services Well Child Care	Birth up to age 18 - Services paid at 100%	Birth up to age 18 - Services paid at 100% for immunization services. Other services up to age 7 - <b>Coinsurance</b> only Other services age 7 up to age 18 - <b>Deductible</b> <b>Coinsurance</b>
Wellness Care Services Annual Physical - Adult	Services paid at 100% <b>Benefit</b> limited to [\$500] per <b>calendar year.</b>	<b>Deductible</b> <b>Coinsurance</b> <b>Benefit</b> limited to [\$250] per <b>calendar year.</b>
Wellness Care Services Well Adult Care  Diphtheria/Tetanus Immunization Cholesterol Screening Bone Mass Measurement	Services paid at 100%	<b>Deductible</b> <b>Coinsurance</b>
Wellness Care Services Cancer Screenings	Services paid at 100%	<b>Deductible</b> <b>Coinsurance</b>
Maternity Services <i>PRE-CERTIFICATION REQUIRED</i> <i>FOR HOSPITAL STAYS OVER THE</i> <i>MINIMUM COVERAGE</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Musculoskeletal Disorders <i>PRE-CERTIFICATION REQUIRED</i> <i>FOR SURGERY</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
Ambulance Services	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Reconstructive Surgery</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Medical Supplies</b> , oxygen and other gases	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Emergency Care</b> Services	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b> For an <b>emergency condition</b> , the <b>network provider deductible</b> and <b>coinsurance</b> apply.

See Page 1 for **Deductible** and **Coinsurance** amounts.

<b>Covered Services</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Durable Medical Equipment</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Prosthetic Devices</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Orthotic Devices</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Home Health Care Services</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Coverage limited to 100 visits per <b>calendar year</b> for <b>network</b> and <b>non-network providers</b> combined.	
<b>Hospice Care Services</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
<b>Transplant Services</b> <i>PRE-CERTIFICATION REQUIRED</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	Additional [\$5,000] for travel and lodging expenses available for transplants done through a transplant <b>network provider</b> at a location more than 150 miles from the <b>covered person's</b> residence.	
<b>Mental Illness Services</b> <b>Chemical Dependency Services</b> <i>PRE-CERTIFICATION REQUIRED</i> <i>FOR INPATIENT AND</i> <i>TRANSITIONAL TREATMENT</i>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>
	For <b>mental illness</b> and <b>chemical dependency</b> services combined, maximum <b>benefit</b> of [\$2,500] per <b>calendar year</b> for <b>outpatient</b> services and [\$50,000] per <b>calendar year</b> for <b>inpatient</b> and transitional treatment combined. <b>Lifetime maximum</b> of [\$100,000] for all <b>mental illness</b> and <b>chemical dependency</b> services.  These sublimits do not apply to <b>serious mental illness</b> .  If the <b>employer</b> has more than 50 <b>employees</b> , these sublimits do not apply.	
<b>Contraceptive Devices</b>	<b>Deductible</b> <b>Coinsurance</b>	<b>Deductible</b> <b>Coinsurance</b>

See Page 1 for **Deductible** and **Coinsurance** amounts.

<b>Covered Services</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Prescription Drugs</b> - on Specialty Drug List <sup>2</sup>	<b>Deductible</b> <b>Coinsurance</b> <sup>1</sup>	<b>Deductible</b> <b>Coinsurance</b> plus the amount charged in excess of the <b>network</b> cost of the drug. <sup>1</sup>
<b>Prescription Drugs</b> - not on Specialty Drug List <sup>2</sup>	<b>Deductible</b> <b>Coinsurance</b> <sup>1</sup>	<b>Deductible</b> <b>Coinsurance</b> plus the amount charged in excess of the <b>network</b> cost of the drug. <sup>1</sup>

<sup>1</sup> Maximum dispensing limits have been set on some **prescription drugs**. Consult pharmacy for details.

<sup>2</sup> Specialty drug list is a list of drugs designated as specialty drugs available through **our** specialty drug program. The list is subject to periodic review and modification. Specialty drugs obtained from sources other than **our** specialty drug program are subject to **non-network deductible and coinsurance** even if obtained through a **provider** that is part of another contracted network.