

State: Arkansas **Filing Company:** Federated Mutual Insurance Company
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: Group Health
Project Name/Number: Qualified Generic Drug 2013/Qualified Generic Drug 2013

Filing at a Glance

Company: Federated Mutual Insurance Company
Product Name: Group Health
State: Arkansas
TOI: H16G Group Health - Major Medical
Sub-TOI: H16G.001A Any Size Group - PPO
Filing Type: Form
Date Submitted: 10/29/2012
SERFF Tr Num: FEMC-128746933
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num:

Implementation: 01/01/2013
Date Requested:
Author(s): Kayla Paape
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 11/05/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Federated Mutual Insurance Company
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: Group Health
Project Name/Number: Qualified Generic Drug 2013/Qualified Generic Drug 2013

General Information

Project Name: Qualified Generic Drug 2013 Status of Filing in Domicile: Not Filed
 Project Number: Qualified Generic Drug 2013 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
 Group Market Type: Employer Overall Rate Impact:
 Filing Status Changed: 11/05/2012 Deemer Date:
 State Status Changed: 11/05/2012 Submitted By: Kayla Paape
 Created By: Kayla Paape
 Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

Federated Mutual Insurance Company is submitting 3 revised Group Health Schedule of Benefit forms, 1 new Group Health Schedule form, 1 new Group Health Rider, 1 revised Employer Application Form, and 1 revised Employee Enrollment Form for your review and approval.

The only changes made to the schedules from the previously approved versions are on pages 2 & 4 of each schedule. On page 2 a definition of a Qualified Generic Drug has been added. On page 4 a Qualified Generic Drug copayment of \$10 for pharmacy and \$20 for mail order has been added. A redline comparison is attached to the Supporting Documentation tab.

The 3 revised Schedules were previously approved by your department on 9/6/2011 under SERFF tracking no. FEMC-127384610/State Tracking No. 49633.

Rider GM 00 01 (01-13 ed.) is being submitted to communicate the schedule changes to existing certificateholders. It will be used for this purpose only.

The schedules will be used in conjunction with policy form GH 03 10 (01-12 ed.) and certificate form GH 03 11 (01-12 ed.) both approved by your department on 9/6/2011 under SERFF tracking no. FEMC-127384610/State Tracking No. 49633.

Company and Contact

Filing Contact Information

Kayla Paape, Compliance Analyst	klpaape@fedins.com
121 East Park Square	800-533-0472 [Phone] 455-8052 [Ext]
Owatonna, MN 55060	507-444-4840 [FAX]

State: Arkansas **Filing Company:** Federated Mutual Insurance Company
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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: \$350.00
 Retaliatory? No
 Fee Explanation: \$50 each for 7 forms
 Per Company: No

Company	Amount	Date Processed	Transaction #
Federated Mutual Insurance Company	\$350.00	10/29/2012	64373474

SERFF Tracking #:

FEMC-128746933

State Tracking #:

Company Tracking #:

State:

Arkansas

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H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO

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Qualified Generic Drug 2013/Qualified Generic Drug 2013

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/05/2012	11/05/2012

SERFF Tracking #:

FEMC-128746933

State Tracking #:**Company Tracking #:****State:**

Arkansas

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H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO

Product Name:

Group Health

Project Name/Number:

Qualified Generic Drug 2013/Qualified Generic Drug 2013

Disposition

Disposition Date: 11/05/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Redline Schedule	Approved-Closed	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	Schedule of Benefits	Approved-Closed	Yes
Form	Employer Enrollment Form	Approved-Closed	Yes
Form	Employee Enrollment and Record Form	Approved-Closed	Yes

State:

Arkansas

Filing Company:

Federated Mutual Insurance Company

TOI/Sub-TOI:

H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO

Product Name:

Group Health

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Qualified Generic Drug 2013/Qualified Generic Drug 2013

Form Schedule

Lead Form Number: HS 03 03 (01-13 ed.)									
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1	Approved-Closed 11/05/2012	Schedule of Benefits	HS 03 03 (01-13 ed.)	SCH	Revised	Previous Filing Number:	FEMC-127384610		HS 03 03 _01-13 ed..pdf
						Replaced Form Number:	HS 03 03 (01-12 ed.)		
2	Approved-Closed 11/05/2012	Schedule of Benefits	HS 03 05 (01-13 ed.)	SCH	Revised	Previous Filing Number:	FEMC-127384610		HS 03 05 _01-13 ed..pdf
						Replaced Form Number:	HS 03 05 (01-12 ed.)		
3	Approved-Closed 11/05/2012	Schedule of Benefits	HS 03 06 (01-13 ed.)	SCH	Revised	Previous Filing Number:	FEMC-127384610		HS 03 06 _01-13 ed..pdf
						Replaced Form Number:	HS 03 06 (01-12 ed.)		
4	Approved-Closed 11/05/2012	Rider	GM 00 01 (01-13 ed.)	POLA	Initial				GM 00 01 _01-13 ed. .pdf
5	Approved-Closed 11/05/2012	Schedule of Benefits	HS 03 05A (01-13 ed.)	SCH	Initial				HS 03 05A _01-13 ed..pdf
6	Approved-Closed 11/05/2012	Employer Enrollment Form	1400 Ed. 02-12	AEF	Revised	Previous Filing Number:	FEMC-127384610		1400 Ed. 02-12.pdf
						Replaced Form Number:	1400 (05-04 ed.)		
7	Approved-Closed 11/05/2012	Employee Enrollment and Record Form	4420 Ed. 01-12	AEF	Revised	Previous Filing Number:	FEMC-127384610		4420 Ed 01-12.pdf
						Replaced Form Number:	4420 Ed. 01-09		

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Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

SCHEDULE OF BENEFITS

Effective Date: [January 1, 2013]

Words and phrases appearing in **bold type** have special meaning as set forth in Section VIII – Definitions or below.

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

	Network Provider	Non-Network Provider
Deductible - Individual	[\$3,000 - \$10,000]	[\$3,000 - \$10,000]
Deductible - Family	[\$6,000- \$20,000]	[\$6,000 - \$20,000]
Coinsurance	[0%]	[25%]
Out-of-Pocket Maximum - Individual	[\$3,000 - \$10,000]	[\$5,500 - \$12,500]
Out-of-Pocket Maximum - Family	[\$6,000 - \$20,000]	[\$11,000 - \$25,000]

2. Pre-certification Requirements

See Section I – General Provisions, 16. Pre-certification Requirements for details on the process.

Pre-certification is required for the following services.

- a. **durable medical equipment**;
- b. diagnostic services:
 - i. CAT scan,
 - ii. MRI,
 - iii. PET scan, and
 - iv. sleep studies;
- c. **home health care services**;
- d. **hospice care services**;
- e. **inpatient** treatment in a **hospital**;
- f. **inpatient** stays for maternity services over the minimum duration listed;
- g. **inpatient** or transitional treatment for **chemical dependency** or **mental illness**;
- h. mastectomy;
- i. **nursing facility** services;
- j. **orthotic devices**;
- k. **prescription drugs** on the prior authorization list;
- l. **prosthetic devices**;
- m. rehabilitative services;
- n. **surgeries**;
- o. therapies:
 - i. **physical therapy**,
 - ii. **occupational therapy**,
 - iii. **speech therapy**, and
 - iv. intravenous therapy; and
- p. transplant services.

3. Definitions

- a. **Brand name drug**

means drugs having the trademarked name of the drug on the package label that is not a **performance drug** or **specialty drug**.

- b. **Coinsurance**

means the amount, calculated using a fixed percentage, paid by a **covered person** for certain **covered expenses**. **Coinsurance** does not carryover from one **calendar year** to the next **calendar year**. **Coinsurance** does not carryover from a prior insurer if the **employer** purchases this **policy** during the **calendar year**.

c. **Copayment**

means a specified dollar amount that a **covered person** is required to pay for certain **covered expenses**. **Copayments** do not apply toward satisfying the **deductible**, **coinsurance** or **out-of-pocket maximum** requirements of the **policy**.

d. **Deductible**

means the amount that must be paid for certain **covered expenses** in a **calendar year** before **we** will begin paying **benefits** in that **calendar year**. **Copayments** do not apply toward satisfying the **deductible**. Expenses that are not **covered expenses** and penalties for failure to follow pre-certification requirements do not apply toward satisfying the **deductible**.

The individual **deductible** is the most each individual **covered person** must pay each **calendar year** before **we** will begin paying **benefits** for that **covered person** in that **calendar year**. However, if the family **deductible** is satisfied the **benefits** will be paid for the **covered employee** and his covered **dependents** even if their individual **deductibles** are not satisfied.

Any amount the **covered person** pays for **covered expenses** in the last three **months** of the previous **calendar year** which are applied to that **calendar year's deductible** will be carried over and applied to the current **deductible**.

If the **employer** purchases this **policy** during the **calendar year**, for **covered persons** that enroll when the **employer's** coverage first becomes effective with **us**, any amount which was applied to the **deductible** for that **covered person** under the **employer's** previous **plan** in that same **calendar year** will be carried over and applied to the **deductible** on the **policy**. The amount of **deductible** carried over from a prior **plan** cannot exceed the amount of the **deductible** on this **plan**.

e. **Generic drug**

means a non-brand name drug that is not a **performance drug** or **specialty drug** which has:

- i. the same active ingredients, strength and dosage form; and
- ii. is determined by the FDA to be therapeutically equivalent to the drug identified in the prescription.

f. **Out-of-pocket Maximum**

means the amount of **deductible** and **coinsurance** that the **covered person** or his family must pay each **calendar year** for **covered expenses** other than **prescription drugs**. **Prescription drug copayments**, expenses that are not **covered expenses** and pre-certification penalties do not apply to the **out-of-pocket maximum**.

The individual **out-of-pocket maximum** is the most each **covered person** must pay each **calendar year** for **deductible** and **coinsurance** for **covered expenses** other than **prescription drugs**. The family **out-of-pocket maximum** is the most each **covered employee** and his covered **dependents** combined must pay each **calendar year** for **deductibles** and **coinsurance** for **covered expenses** other than **prescription drugs**.

g. **Performance drug**

means drugs appearing on a list of **generic drugs** and **brand name drugs** designated for use as **performance drugs**. The list is subject to periodic review and modification. The list is available at www.express-scripts.com.

h. **Qualified Generic Drugs**

means drugs appearing on a list of generic drugs designated for use as a **qualified generic drugs**. The list is subject to periodic review and modification. The list is available at www.express-scripts.com.

i. **Specialty drug**

means a list of **generic drugs** and **brand name drugs** designated for use as **specialty drugs**. The list is subject to periodic review and modification. The list is available at www.express-scripts.com.

4. Duration and coverage limits

Autism spectrum disorders	For a covered person up to age 18 diagnosed with "autism spectrum disorders" coverage for "applied behavior analysis" therapy is limited to \$50,000 per calendar year .
Hearing aids	Coverage is limited to \$1,400 per ear every 3 years.
Home health care services	Coverage limited to [100 visits] per calendar year for network and non-network providers combined
In vitro fertilization	Coverage is limited to a lifetime maximum of \$15,000.
Manipulative therapy	Maximum of [26 visits] for manipulative therapy and related services are payable in any calendar year .
Mental illness and chemical dependency services	<p>For mental illness and chemical dependency services combined, maximum benefit of [\$2,500] per calendar year for outpatient services and [\$50,000] per calendar year for inpatient and transitional treatment combined. Lifetime maximum of [\$100,000] for all mental illness and chemical dependency services.</p> <p>If the employer has more than 50 employees these sublimits do not apply.</p> <p>These sublimits do not apply to serious mental illness or biologically based mental illness.</p>
Nursing facility charges	Maximum of [60 days] per confinement with a total of [60 days] per illness or injury .
Prescription Drugs	<p>Maximum dispensing limits have been set on some prescription drugs. Consult your pharmacy for details.</p> <p>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.</p> <p>If the covered person requests a brand name drug when a generic drug is available, he will pay the brand name drug copayment plus the difference in cost between the brand name drug and the generic drug.</p> <p>Specialty drugs obtained from sources other than the specialty drug network provider are subject to non-network specialty drug copayments plus the amount charged in excess of the network cost of the drug.</p> <p>Specialty drugs obtained as an inpatient, from a physician or from a hospital are subject to non-network specialty drug copayments plus the amount charged in excess of the network cost of the drug not deductible and coinsurance like other drugs received from these sources.</p> <p>The cost of prescription drugs in excess of the network cost of the drugs are not covered expenses.</p> <p>Some prescription drugs require prior authorization to be covered. Consult your pharmacy for details.</p>

5. **Benefits for covered expenses** will be paid subject to the following schedule. Refer to Section VI - **Covered Services** for details of what services are covered.

Covered Services	Network Provider	Non-Network Provider
All covered services not listed below	Deductible Coinsurance	Deductible Coinsurance
Emergency care services	Deductible Coinsurance	Deductible Coinsurance For an emergency condition , the network provider deductible and coinsurance apply.
Preventive care services	Services paid at 100%	Deductible Coinsurance
Annual physical	Benefit limited to [\$500 - \$1,000] per calendar year .	Deductible Coinsurance Benefit limited to [\$250 - \$500] per calendar year .
Qualified Generic Drugs	Copayment of [\$0 - \$25 / 31 day] supply	Copayment of [\$0 - \$25 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Generic drugs	Deductible then Copayment of [\$0 - \$25 / 31 day] supply	Deductible then Copayment of [\$0 - \$25 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Performance Drugs	Deductible then Copayment of [\$0 - \$60 / 31 day] supply	Deductible then Copayment of [\$0 - \$60 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Brand name drugs	Deductible then Copayment of [\$0 - \$100 / 31 day] supply	Deductible then Copayment of [\$0 - \$100 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Specialty drugs	Deductible then Copayment of [\$0 - \$250 / 31 day] supply	Deductible then Copayment of [\$0 - \$250 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Qualified Generic Drugs –mail order	Copayment of [\$0 - \$50 / 90 day] supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider . If pharmacy agrees to terms and conditions, mail order copayment will apply.
Generic drugs – mail order	Deductible then Copayment of [\$0 - \$70 / 90 day] supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider . If pharmacy agrees to terms and conditions, mail order copayment will apply.
Performance Drugs – mail order	Deductible then Copayment of [\$0 - \$180 / 90 day] supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider . If pharmacy agrees to terms and conditions, mail order copayment will apply.
Brand name drugs – mail order	Deductible then Copayment of [\$0 - \$250 / 90 day] supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider . If pharmacy agrees to terms and conditions, mail order copayment will apply.
Prescription drugs , other than specialty drugs , received as an inpatient or from a hospital or from a physician's office	Deductible Coinsurance	Deductible Coinsurance

SCHEDULE OF BENEFITS

Effective Date: [January 1, 2013]

Words and phrases appearing in **bold type** have special meaning as set forth in Section VIII – Definitions or below.

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

	Network Provider	Non-Network Provider
Employee only coverage		
Deductible	[\$2,500 - \$6,000]	[\$2,500 - \$6,000]
Coinsurance	[0% - 20%]	[25% - 45%]
Out-of-Pocket Maximum	[\$2,500 - \$6,000]	[\$5,000 - \$10,500]
Family coverage		
Deductible – individual	[\$2,500 - \$6,000]	[\$2,500 - \$6,000]
Deductible - family	[\$5,000 - \$12,000]	[\$5,000 - \$12,000]
Coinsurance	[0% - 20%]	[25% - 45%]
Out-of-Pocket Maximum individual	[\$2,500 - \$6,000]	[\$5,000 - \$10,500]
Out-of-Pocket Maximum family	[\$5,000 - \$12,000]	[\$9,600 - \$21,000]

The **deductible** and **out-of-pocket maximums** may be adjusted annually based on the Consumer Price Index (CPI) published by the US Department of Labor.

2. Pre-certification Requirements

See Section I – General Provisions, 16. Pre-certification Requirements for details on the process.

Pre-certification is required for the following services.

- a. **durable medical equipment;**
- b. diagnostic services:
 - i. CAT scan,
 - ii. MRI,
 - iii. PET scan, and
 - iv. sleep studies;
- c. **home health care services;**
- d. **hospice care services;**
- e. **inpatient** treatment in a **hospital;**
- f. **inpatient** stays for maternity services over the minimum duration listed;
- g. **inpatient** or transitional treatment for **chemical dependency or mental illness;**
- h. mastectomy;
- i. **nursing facility** services;
- j. **orthotic devices;**
- k. **prescription drugs** on the prior authorization list;
- l. **prosthetic devices;**
- m. rehabilitative services;
- n. **surgeries;**
- o. therapies:
 - i. **physical therapy,**
 - ii. **occupational therapy,**
 - iii. **speech therapy,** and
 - iv. intravenous therapy; and
- p. transplant services.

3. Definitions

a. **Brand name drug**

means drugs having the trademarked name of the drug on the package label that is not a **performance drug** or **specialty drug**.

b. **Coinsurance**

means the amount, calculated using a fixed percentage, paid by a **covered person** for certain **covered expenses**. **Coinsurance** does not carryover from one **calendar year** to the next **calendar year**. **Coinsurance** does not carryover from a prior insurer if the **employer** purchases this **policy** during the **calendar year**.

c. **Copayment**

means a specified dollar amount that a **covered person** is required to pay for certain **covered expenses**.

d. **Deductible**

means the amount that must be paid for certain **covered expenses** in a **calendar year** before **we** will begin paying **benefits** in that **calendar year**. Expenses that are not **covered expenses** and penalties for failure to follow pre-certification requirements do not apply toward satisfying the **deductible**.

If family coverage is purchased the “**employee only coverage**” **deductible** is the most each individual **covered person** must pay each **calendar year** before **we** will begin paying **benefits** for that **covered person** in that **calendar year**. However, if the family **deductible** is satisfied the **benefits** will be paid for the **covered employee** and his covered **dependents** even if their individual **deductibles** are not satisfied.

Deductible does not carryover from one **calendar year** to the next **calendar year**.

If the **employer** purchases this **policy** during the **calendar year**, for **covered persons** that enroll when the **employer’s** coverage first becomes effective with **us**, any amount which was applied to the **deductible** for that **covered person** under the **employer’s** previous **plan** in that same **calendar year** will be carried over and applied to the **deductible** on the **policy**. The amount of **deductible** carried over from a prior **plan** cannot exceed the amount of the **deductible** on this **plan**.

e. **Generic drug**

means a non-brand name drug that is not a **performance drug** or **specialty drug** which has:

- i. the same active ingredients, strength and dosage form; and
- ii. is determined by the FDA to be therapeutically equivalent to the drug identified in the prescription.

f. **Out-of-pocket Maximum**

means the amount of **deductible**, **copayment** and **coinsurance** that the **covered person** or his family must pay each **calendar year** for **covered expenses**. Expenses that are not **covered expenses** and pre-certification penalties do not apply to the **out-of-pocket maximum**.

If family coverage is purchased the “**employee only coverage**” **out-of-pocket maximum** is the most each **covered person** must pay each **calendar year** for **deductible**, **copayments** and **coinsurance** for **covered expenses**. The family **out-of-pocket maximum** is the most each **covered employee** and his covered **dependents** combined must pay each **calendar year** for **deductible**, **copayments** and **coinsurance** for **covered expenses**.

g. **Performance drug**

means drugs appearing on a list of **generic drugs** and **brand name drugs** designated for use as **performance drugs**. The list is subject to periodic review and modification. The list is available at www.express-scripts.com.

h. **Qualified Generic Drugs**

means drugs appearing on a list of generic drugs designated for use as a **qualified generic drugs**. The list is subject to periodic review and modification. The list is available at www.express-scripts.com.

i. **Specialty drug**

means a list of **generic drugs** and **brand name drugs** designated for use as **specialty drugs**. The list is subject to periodic review and modification. The list is available at www.express-scripts.com.

4. Duration and coverage limits

Autism spectrum disorders	For a covered person up to age 18 diagnosed with "autism spectrum disorders" coverage for "applied behavior analysis" therapy is limited to \$50,000 per calendar year .
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Home health care services	Coverage limited to [100 visits] per calendar year for network and non-network providers combined.
In vitro fertilization	Coverage is limited to a lifetime maximum of \$15,000.
Manipulative therapy	Maximum of [26 visits] for manipulative therapy and related services are payable in any calendar year .
Mental illness and chemical dependency services	<p>For mental illness and chemical dependency services combined, maximum benefit of [\$2,500] per calendar year for outpatient services and [\$50,000] per calendar year for inpatient and transitional treatment combined. Lifetime maximum of [\$100,000] for all mental illness and chemical dependency services.</p> <p>If the employer has more than 50 employees these sublimits do not apply.</p> <p>These sublimits do not apply to serious mental illness or biologically based mental illness.</p>
Nursing facility charges	Maximum of [60 days] per confinement with a total of [60 days] per illness or injury .
Prescription Drugs	<p>Maximum dispensing limits have been set on some prescription drugs. Consult your pharmacy for details.</p> <p>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.</p> <p>If the covered person requests a brand name drug when a generic drug is available, he will pay the brand name drug copayment plus the difference in cost between the brand name drug and the generic drug.</p> <p>Specialty drugs obtained from sources other than the specialty drug network provider are subject to non-network specialty drug copayments plus the amount charged in excess of the network cost of the drug.</p> <p>Specialty drugs obtained as an inpatient, from a physician or from a hospital are subject to non-network specialty drug copayments plus the amount charged in excess of the network cost of the drug not deductible and coinsurance like other drugs received from these sources.</p> <p>The cost of prescription drugs in excess of the network cost of the drugs are not covered expenses.</p> <p>Some prescription drugs require prior authorization to be covered. Consult your pharmacy for details.</p>

5. **Benefits for covered expenses** will be paid subject to the following schedule. Refer to Section VI - **Covered Services** for details of what services are covered.

Covered Services	Network Provider	Non-Network Provider
All covered services not listed below	Deductible Coinsurance	Deductible Coinsurance
Emergency care services	Deductible Coinsurance	Deductible Coinsurance For an emergency condition , the network provider deductible and coinsurance apply.
Preventive care services	Services paid at 100%	Deductible Coinsurance
Annual physical	Benefit limited to [\$500 - \$1,000] per calendar year .	Deductible Coinsurance Benefit limited to [\$250 - \$500] per calendar year .
Qualified Generic Drugs	Copayment of [\$0 - \$25 / 31 day] supply	Copayment of [\$0 - \$25 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Generic drugs	Deductible then Copayment of [\$0 - \$25 / 31 day] supply	Deductible then Copayment of [\$0 - \$25 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Performance Drugs	Deductible then Copayment of [\$0 - \$60 / 31 day] supply	Deductible then Copayment of [\$0 - \$60 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Brand name drugs	Deductible then Copayment of [\$0 - \$100 / 31 day] supply	Deductible then Copayment of [\$0 - \$100 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Specialty drugs	Deductible then Copayment of [\$0 - \$250 / 31 day] supply	Deductible then Copayment of [\$0 - \$250 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Qualified Generic Drugs –mail order	Copayment of [\$0 - \$50 / 90 day] supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider . If pharmacy agrees to terms and conditions, mail order copayment will apply.
Generic drugs – mail order	Deductible then Copayment of [\$0 - \$70 / 90 day] supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider . If pharmacy agrees to terms and conditions, mail order copayment will apply.
Performance Drugs – mail order	Deductible then Copayment of [\$0 - \$180 / 90 day] supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider . If pharmacy agrees to terms and conditions, mail order copayment will apply.
Brand name drugs – mail order	Deductible then Copayment of [\$0 - \$250 / 90 day] supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider . If pharmacy agrees to terms and conditions, mail order copayment will apply.
Prescription drugs , other than specialty drugs , received as an inpatient or from a hospital or from a physician's office	Deductible Coinsurance	Deductible Coinsurance

SCHEDULE OF BENEFITS

Effective Date: [January 1, 2013]

Words and phrases appearing in **bold type** have special meaning as set forth in Section VIII – Definitions or below.

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

	Network Provider	Non-Network Provider
Employee only coverage		
Deductible	[\$1,250 - \$2,500]	[\$1,250 – \$2,500]
Coinsurance	[20%]	[45%]
Out-of-Pocket Maximum	[\$6,000 - \$12,000]	[\$7,500 – \$15,000]
Family coverage		
Deductible	[\$2,500 - \$4,800]	[\$2,500 - \$4,800]
Coinsurance	[20%]	[45%]
Out-of-Pocket Maximum	[\$12,000 - \$20,000]	[\$15,000 – \$20,000]

The **deductible** and **out-of-pocket maximums** may be adjusted annually based on the Consumer Price Index (CPI) published by the US Department of Labor.

2. Pre-certification Requirements

See Section I – General Provisions, 16. Pre-certification Requirements for details on the process.

Pre-certification is required for the following services.

- a. **durable medical equipment**;
- b. diagnostic services:
 - i. CAT scan,
 - ii. MRI,
 - iii. PET scan, and
 - iv. sleep studies;
- c. **home health care services**;
- d. **hospice care services**;
- e. **inpatient** treatment in a **hospital**;
- f. **inpatient** stays for maternity services over the minimum duration listed;
- g. **inpatient** or transitional treatment for **chemical dependency** or **mental illness**;
- h. mastectomy;
- i. **nursing facility** services;
- j. **orthotic devices**;
- k. **prescription drugs** on the prior authorization list;
- l. **prosthetic devices**;
- m. rehabilitative services;
- n. **surgeries**;
- o. therapies:
 - i. **physical therapy**,
 - ii. **occupational therapy**,
 - iii. **speech therapy**, and
 - iv. intravenous therapy; and
- p. transplant services.

3. Definitions

a. **Brand name drug**

means drugs having the trademarked name of the drug on the package label that is not a **performance drug** or **specialty drug**.

b. **Coinsurance**

means the amount, calculated using a fixed percentage, paid by a **covered person** for certain **covered expenses**. **Coinsurance** does not carryover from one **calendar year** to the next **calendar year**. **Coinsurance** does not carryover from a prior insurer if the **employer** purchases this **policy** during the **calendar year**.

c. **Copayment**

means a specified dollar amount that a **covered person** is required to pay for certain **covered expenses**.

d. **Deductible**

means the amount that must be paid for certain **covered expenses** in a **calendar year** before we will begin paying **benefits** in that **calendar year**. Expenses that are not **covered expenses** and penalties for failure to follow pre-certification requirements do not apply toward satisfying the **deductible**.

If family coverage is purchased the family **deductible** must be satisfied before any **benefits** will be paid for the **covered employee** and his covered **dependents**.

Deductible does not carryover from one **calendar year** to the next **calendar year**.

If the **employer** purchases this **policy** during the **calendar year**, for **covered persons** that enroll when the **employer's** coverage first becomes effective with us, any amount which was applied to the **deductible** for that **covered person** under the **employer's** previous **plan** in that same **calendar year** will be carried over and applied to the **deductible** on the **policy**. The amount of **deductible** carried over from a prior **plan** cannot exceed the amount of the **deductible** on this **plan**.

e. **Generic drug**

means a non-brand name drug that is not a **performance drug** or **specialty drug** which has:

- i. the same active ingredients, strength and dosage form; and
- ii. is determined by the FDA to be therapeutically equivalent to the drug identified in the prescription.

f. **Out-of-pocket Maximum**

means the amount of **deductible**, **copayment** and **coinsurance** that the **covered person** or his family must pay each **calendar year** for **covered expenses**. Expenses that are not **covered expenses** and pre-certification penalties do not apply to the **out-of-pocket maximum**.

If family coverage is purchased the family **out-of-pocket maximum** must be met for the **covered employee** and his covered **dependents** combined each **calendar year** for **deductibles**, **copayments** and **coinsurance** for **covered expenses**.

g. **Performance drug**

means drugs appearing on a list of **generic drugs** and **brand name drugs** designated for use as **performance drugs**. The list is subject to periodic review and modification. The list is available at www.express-scripts.com.

h. **Qualified Generic Drugs**

means drugs appearing on a list of generic drugs designated for use as a **qualified generic drugs**. The list is subject to periodic review and modification. The list is available at www.express-scripts.com.

i. **Specialty drug**

means a list of **generic drugs** and **brand name drugs** designated for use as **specialty drugs**. The list is subject to periodic review and modification. The list is available at www.express-scripts.com.

4. Duration and coverage limits

Autism spectrum disorders	For a covered person up to age 18 diagnosed with "autism spectrum disorders" coverage for "applied behavior analysis" therapy is limited to \$50,000 per calendar year .
Hearing aids	Coverage is limited to \$1,400 per ear every 3 years.
Home health care services	Coverage limited to [100 visits] per calendar year for network and non-network providers combined
In vitro fertilization	Coverage is limited to a lifetime maximum of \$15,000.
Manipulative therapy	Maximum of [26 visits] for manipulative therapy and related services are payable in any calendar year
Mental illness and chemical dependency services	<p>For mental illness and chemical dependency services combined, maximum benefit of [\$2,500] per calendar year for outpatient services and [\$50,000] per calendar year for inpatient and transitional treatment combined. Lifetime maximum of [\$100,000] for all mental illness and chemical dependency services.</p> <p>If the employer has more than 50 employees these sublimits do not apply.</p> <p>These sublimits do not apply to serious mental illness or biologically based mental illness.</p>
Nursing facility charges	Maximum of [60 days] per confinement with a total of [60 days] per illness or injury .
Prescription Drugs	<p>Maximum dispensing limits have been set on some prescription drugs. Consult your pharmacy for details.</p> <p>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.</p> <p>If the covered person requests a brand name drug when a generic drug is available, he will pay the brand name drug copayment plus the difference in cost between the brand name drug and the generic drug.</p> <p>Specialty drugs obtained from sources other than the specialty drug network provider are subject to non-network specialty drug copayments plus the amount charged in excess of the network cost of the drug.</p> <p>Specialty drugs obtained as an inpatient, from a physician or from a hospital are subject to non-network specialty drug copayments plus the amount charged in excess of the network cost of the drug not deductible and coinsurance like other drugs received from these sources.</p> <p>The cost of prescription drugs in excess of the network cost of the drugs are not covered expenses.</p> <p>Some prescription drugs require prior authorization to be covered. Consult your pharmacy for details.</p>

5. **Benefits for covered expenses** will be paid subject to the following schedule. Refer to Section VI - **Covered Services** for details of what services are covered.

Covered Services	Network Provider	Non-Network Provider
All covered services not listed below	Deductible Coinsurance	Deductible Coinsurance
Emergency care services	Deductible Coinsurance	Deductible Coinsurance For an emergency condition , the network provider deductible and coinsurance apply.
Preventive care services	Services paid at 100%	Deductible Coinsurance
Annual physical	Benefit limited to [\$500 - \$1,000] per calendar year .	Deductible Coinsurance Benefit limited to [\$250 - \$500] per calendar year .
Qualified Generic Drugs	Copayment of [\$0 - \$25 / 31 day] supply	Copayment of [\$0 - \$25 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Generic drugs	Deductible then Copayment of [\$0 - \$25 / 31 day]	Deductible then Copayment of [\$0 - \$25 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Performance Drugs	Deductible then Copayment of [\$0 - \$60 / 31 day] supply	Deductible then Copayment of [\$0 - \$60 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Brand name drugs	Deductible then Copayment of [\$0 - \$100 / 31 day] supply	Deductible then Copayment of [\$0 - \$100 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Specialty drugs	Deductible then Copayment of [\$0 - \$250 / 31 day] supply	Deductible then Copayment of [\$0 - \$250 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Qualified Generic Drugs –mail order	Copayment of [\$0 - \$50 / 90 day] supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider . If pharmacy agrees to terms and conditions, mail order copayment will apply.
Generic drugs – mail order	Deductible then Copayment of [\$0 - \$70 / 90 day] supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider . If pharmacy agrees to terms and conditions, mail order copayment will apply.
Performance Drugs – mail order	Deductible then Copayment of [\$0 - \$180 / 90 day] supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider . If pharmacy agrees to terms and conditions, mail order copayment will apply.
Brand name drugs – mail order	Deductible then Copayment of [\$0 - \$250 / 90 day] supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider . If pharmacy agrees to terms and conditions, mail order copayment will apply.
Prescription drugs , other than specialty drugs , received as an inpatient or from a hospital or from a physician's office	Deductible Coinsurance	Deductible Coinsurance

FEDERATED MUTUAL
INSURANCE COMPANY
HOME OFFICE: 121 East Park Square, Owatonna, Minnesota 55060
Phone: 800-533-0472

GROUP HEALTH POLICY AND CERTIFICATE RIDER

RIDER EFFECTIVE DATE: [January 1, 2013]

The policy and certificate are changed as follows:

1. The Schedule of Benefits, 3. Definitions, is changed as follows:

h. **Qualified Generic Drugs**

means drugs appearing on a list of generic drugs designated for use as a **qualified generic drugs**. The list is subject to periodic review and modification. The list is available at www.express-scripts.com.

i. **Specialty drug**

means a list of generic drugs and brand name drugs designated for use as specialty drugs. The list is subject to periodic review and modification. The list is available at www.express-scripts.com.

2. The following is added to the Schedule of Benefits, 5. **Benefits**:

Covered Services	Network Provider	Non-Network Provider
Qualified Generic Drugs	Copayment of [\$0 - \$25 / 31 day] supply	Copayment of [\$0 - \$25 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Qualified Generic Drugs –mail order	Copayment of [\$0 - \$50 / 90 day] supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider . If pharmacy agrees to terms and conditions, mail order copayment will apply.

SECRETARY

PRESIDENT

SCHEDULE OF BENEFITS

Effective Date: [January 1, 2013]

Words and phrases appearing in **bold type** have special meaning as set forth in Section VIII – Definitions or below.

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

	Network Provider	Non-Network Provider
Employee only coverage		
Deductible	[\$2,500 - \$5,000]	[\$2,500 - \$5,000]
Coinsurance	[0% - 20%]	[25% - 45%]
Out-of-Pocket Maximum	[\$2,500 - \$5,000]	[\$5,000 - \$10,500]
Family coverage		
Deductible – individual	[\$2,500 - \$5,000]	[\$2,500 - \$5,000]
Deductible - family	[\$5,000 - \$10,000]	[\$5,000 - \$10,000]
Coinsurance	[0% - 20%]	[25% - 45%]
Out-of-Pocket Maximum individual	[\$2,500 - \$5,000]	[\$5,000 - \$10,500]
Out-of-Pocket Maximum family	[\$5,000 - \$10,000]	[\$9,600 - \$21,000]

The **deductible** and **out-of-pocket maximums** may be adjusted annually based on the Consumer Price Index (CPI) published by the US Department of Labor.

2. Pre-certification Requirements

See Section I – General Provisions, 16. Pre-certification Requirements for details on the process.

Pre-certification is required for the following services.

- a. **durable medical equipment**;
- b. diagnostic services:
 - i. CAT scan,
 - ii. MRI,
 - iii. PET scan, and
 - iv. sleep studies;
- c. **home health care services**;
- d. **hospice care services**;
- e. **inpatient** treatment in a **hospital**;
- f. **inpatient** stays for maternity services over the minimum duration listed;
- g. **inpatient** or transitional treatment for **chemical dependency** or **mental illness**;
- h. mastectomy;
- i. **nursing facility** services;
- j. **orthotic devices**;
- k. **prescription drugs** on the prior authorization list;
- l. **prosthetic devices**;
- m. rehabilitative services;
- n. **surgeries**;
- o. therapies:
 - i. **physical therapy**,
 - ii. **occupational therapy**,
 - iii. **speech therapy**, and
 - iv. intravenous therapy; and
- p. transplant services.

3. Definitions

a. **Brand name drug**

means drugs having the trademarked name of the drug on the package label that is not a **performance drug** or **specialty drug**.

b. **Coinsurance**

means the amount, calculated using a fixed percentage, paid by a **covered person** for certain **covered expenses**. **Coinsurance** does not carryover from one **calendar year** to the next **calendar year**. **Coinsurance** does not carryover from a prior insurer if the **employer** purchases this **policy** during the **calendar year**.

c. **Copayment**

means a specified dollar amount that a **covered person** is required to pay for certain **covered expenses**.

d. **Deductible**

means the amount that must be paid for certain **covered expenses** in a **calendar year** before **we** will begin paying **benefits** in that **calendar year**. Expenses that are not **covered expenses** and penalties for failure to follow pre-certification requirements do not apply toward satisfying the **deductible**.

If family coverage is purchased the “**employee only coverage**” **deductible** is the most each individual **covered person** must pay each **calendar year** before **we** will begin paying **benefits** for that **covered person** in that **calendar year**. However, if the family **deductible** is satisfied the **benefits** will be paid for the **covered employee** and his covered **dependents** even if their individual **deductibles** are not satisfied.

Deductible does not carryover from one **calendar year** to the next **calendar year**.

If the **employer** purchases this **policy** during the **calendar year**, for **covered persons** that enroll when the **employer’s** coverage first becomes effective with **us**, any amount which was applied to the **deductible** for that **covered person** under the **employer’s** previous **plan** in that same **calendar year** will be carried over and applied to the **deductible** on the **policy**. The amount of **deductible** carried over from a prior **plan** cannot exceed the amount of the **deductible** on this **plan**.

e. **Generic drug**

means a non-brand name drug that is not a **performance drug** or **specialty drug** which has:

- i. the same active ingredients, strength and dosage form; and
- ii. is determined by the FDA to be therapeutically equivalent to the drug identified in the prescription.

f. **Out-of-pocket Maximum**

means the amount of **deductible**, **copayment** and **coinsurance** that the **covered person** or his family must pay each **calendar year** for **covered expenses**. Expenses that are not **covered expenses** and pre-certification penalties do not apply to the **out-of-pocket maximum**.

If family coverage is purchased the “**employee only coverage**” **out-of-pocket maximum** is the most each **covered person** must pay each **calendar year** for **deductible**, **copayments** and **coinsurance** for **covered expenses**. The family **out-of-pocket maximum** is the most each **covered employee** and his covered **dependents** combined must pay each **calendar year** for **deductible**, **copayments** and **coinsurance** for **covered expenses**.

g. **Performance drug**

means drugs appearing on a list of **generic drugs** and **brand name drugs** designated for use as **performance drugs**. The list is subject to periodic review and modification. The list is available at www.express-scripts.com.

h. **Qualified Generic Drugs**

means drugs appearing on a list of generic drugs designated for use as a **qualified generic drugs**. The list is subject to periodic review and modification. The list is available at www.express-scripts.com.

i. **Specialty drug**

means a list of **generic drugs** and **brand name drugs** designated for use as **specialty drugs**. The list is subject to periodic review and modification. The list is available at www.express-scripts.com.

4. Duration and coverage limits

Autism spectrum disorders	For a covered person up to age 18 diagnosed with "autism spectrum disorders" coverage for "applied behavior analysis" therapy is limited to \$50,000 per calendar year .
Hearing aids	Coverage is limited to \$1,400 per ear every 3 years.
Home health care services	Coverage limited to [100 visits] per calendar year for network and non-network providers combined.
In vitro fertilization	Coverage is limited to a lifetime maximum of \$15,000.
Manipulative therapy	Maximum of [26 visits] for manipulative therapy and related services are payable in any calendar year .
Mental illness and chemical dependency services	For mental illness and chemical dependency services combined, maximum benefit of [\$2,500] per calendar year for outpatient services and [\$50,000] per calendar year for inpatient and transitional treatment combined. Lifetime maximum of [\$100,000] for all mental illness and chemical dependency services. If the employer has more than 50 employees these sublimits do not apply. These sublimits do not apply to serious mental illness or biologically based mental illness .
Nursing facility charges	Maximum of [60 days] per confinement with a total of [60 days] per illness or injury .
Prescription Drugs	Maximum dispensing limits have been set on some prescription drugs . Consult your pharmacy for details. 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 brand name drug copayment plus the difference in cost between the brand name drug and the generic drug . Specialty drugs obtained from sources other than the specialty drug network provider are subject to non-network specialty drug copayments plus the amount charged in excess of the network cost of the drug. Specialty drugs obtained as an inpatient , from a physician or from a hospital are subject to non-network specialty drug copayments plus the amount charged in excess of the network cost of the drug not deductible and coinsurance like other drugs received from these sources. The cost of prescription drugs in excess of the network cost of the drugs are not covered expenses . Some prescription drugs require prior authorization to be covered. Consult your pharmacy for details.

5. **Benefits for covered expenses** will be paid subject to the following schedule. Refer to Section VI - **Covered Services** for details of what services are covered.

Covered Services	Network Provider	Non-Network Provider
All covered services not listed below	Deductible Coinsurance	Deductible Coinsurance
Emergency care services	Deductible Coinsurance	Deductible Coinsurance For an emergency condition , the network provider deductible and coinsurance apply.
Preventive care services	Services paid at 100%	Deductible Coinsurance
Annual physical	Benefit limited to [\$500 - \$1,000] per calendar year .	Deductible Coinsurance Benefit limited to [\$250 - \$500] per calendar year .
Qualified Generic Drugs	Copayment of [\$0 - \$25 / 31 day] supply	Copayment of [\$0 - \$25 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Generic drugs	Deductible then Coinsurance for a 31 day supply	Deductible then Coinsurance for a 31 day supply plus the amount charged in excess of the network cost of the drug
Performance Drugs	Deductible then Coinsurance for a 31 day supply	Deductible then Coinsurance for a 31 day supply plus the amount charged in excess of the network cost of the drug
Brand name drugs	Deductible then Coinsurance for a 31 day supply	Deductible then Coinsurance for a 31 day supply plus the amount charged in excess of the network cost of the drug
Specialty drugs	Deductible then Coinsurance for a 31 day supply	Deductible then Coinsurance for a 31 day supply plus the amount charged in excess of the network cost of the drug
Qualified Generic Drugs –mail order	Copayment of [\$0 - \$50 / 90 day] supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider . If pharmacy agrees to terms and conditions, mail order copayment will apply.
Generic drugs – mail order	Deductible then Coinsurance for a 90 day supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider . If pharmacy agrees to terms and conditions, mail order copayment will apply.
Performance Drugs – mail order	Deductible then Coinsurance for a 90 day supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider . If pharmacy agrees to terms and conditions, mail order copayment will apply.
Brand name drugs – mail order	Deductible then Coinsurance for a 90 day supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider . If pharmacy agrees to terms and conditions, mail order copayment will apply.
Prescription drugs , other than specialty drugs , received as an inpatient or from a hospital or from a physician's office	Deductible Coinsurance	Deductible Coinsurance

- Federated Mutual Insurance Company
- Federated Life Insurance Company



Federated Life Insurance Company
 Federated Mutual Insurance Company
 Home Office: Owatonna, MN 55060

Employer Application Form, Contribution and Participation Agreement to Federated Health Choice

Section I: General Information

1. **Employer's Legal Name:** _____ Phone No.: _____
 _____ Fax No.: _____
2. **Employer's Address:** _____
 _____ County: _____
 FEIN #: _____
3. **Name and Title of Contact Person:** _____
4. **Name and Title of the Plan Administrator:** _____
5. **Business is:** Corporation Partnership Proprietorship Other: _____
 Are any affiliated companies or subsidiaries to be included with the employer named above? Yes No
 If "yes", explain and give details including names, addresses, number of employees and financial relationships.

6. **Nature of Employer's Business:** _____ Date Established: _____
7. **Number of Persons Employed:** Part-time _____ Full-time _____ Total _____
Number of Employees:
 Enrolling _____ In Waiting Period _____ Covered Under Separate Employer's Plan _____
8. Does Employer employ any **temporary, seasonal, commissioned or contract** individuals? Yes No
 If "yes", explain: _____
9. **Are there any classes of employee (other than part-time) to be excluded from participation?** Yes No
 If "yes", explain (number to be excluded): _____
10. **Are all employees covered by Social Security?** Yes No **Workers Compensation?** Yes No
 Give the names of those who are not: _____
11. **Is this plan intended to replace any existing group health coverage?** Yes No **Dental Coverage?** Yes No
12. **Is this plan intended to be in addition to any other group Life and/or Health presently in force?** Yes No
13. **Employer Contributions:**
 Please indicate the percent of monthly premium or specific dollar amount the employer pays toward the cost of:
 Employee's Health _____ Life _____ Disability Income _____
 Dependent's Health _____ Dental _____ Other _____

Section II: Benefits Applied For

- Health Plan #:** _____ **Requested Effective Date:** _____
- Deductible:** _____ **Coinsurance:** _____ **PPO Network Name:** _____
- Waiting Period - 1st of the month following:** 1 month 2 months 3 months
- Dental: *** None \$500 \$1,000 \$1,500 \$2,000
- Disability Income:** None \$100 \$150 \$200 \$300 \$400 \$500
- Life Insurance: **** None Level Amount \$ _____
- Class Based Class I definition _____ Amount \$ _____
- Class II definition _____ Amount \$ _____
- Class III definition _____ Amount \$ _____

* Limited to employers with 5 or more enrolled for health. New firms need to be replacing dental to qualify for \$1,000 benefit.

** Amounts reduce at age 65, 70 and 75. See proposal.

Section III: Employer's Agreement

The undersigned employer agrees:

1. That the information provided in this enrollment form is complete and true and will be the basis upon which insurance may be approved under the policy.
2. That only persons who are actively working at least 30 hours per week on a regular basis for the undersigned employer are eligible for insurance.
3. That if the employer is paying the entire cost of the plan, 100% of eligible employees and dependents not covered under a separate employer's plan will be enrolled at all times.
4. That if employees contribute to the cost of the plan, a minimum of 85% of all eligible employees and dependents not covered under a separate employer's plan will be enrolled on the plan at all times.
5. That in no event will the employer's purchase of the policy be approved or continued unless a minimum of 2 eligible employees are always insured by the plan. (Does not apply where state law prohibits)
6. That all new full-time employees are eligible for participation in this plan on the first day of the month following completion of the waiting period designated under Section II.
7. That no insurance will become effective without approval by Federated Mutual Insurance Company and Federated Life Insurance Company from its Home Office and no coverage will become effective on any employee or dependent who does not meet the eligibility provisions of the policy.
8. To contribute a percentage or dollar amount equivalent to a minimum of 70% of the employee premium or 35% of total employee and dependent premium.
9. The undersigned employer is the Plan Sponsor and Plan Administrator for the employer's Employee Security Benefits Plan.
10. If approved for insurance under the policies:
 - A. The employer is bound by all the provisions of the insurance policies issued by Federated to the employer and as those policies may from time to time be amended.
 - B. The employer will remit and initial deposit equal to the first month's premium and pay all subsequent premium by the first of the month as they come due and that failure to remit the required premium may result in termination of coverage.
 - C. The employer will make the program of insurance available to all eligible employees and their eligible dependents.
 - D. The employer will furnish to Federated or its designated agent any information required in connection with administration of the Plan.

Section IV: Signature

The employer requests that Federated Mutual Insurance Company and Federated Life Insurance Company, hereinafter called Federated, approve it for coverage under the insurance policies.

On behalf of the Employer, I hereby certify that I have read this application form and that the information provided is true and accurate.

Employer's Legal Name: _____

Authorized Signature: _____ Title: _____

Print Name: _____ Date: _____

Witness: _____

_____ Territory Code: _____

Agent's Name (print, type of stamp)

NOTICE: Any person who, with intent to injure, defraud or deceive any insurance company, submits a statement of claim or application containing false, incomplete or misleading information, may be subject to criminal and/or civil penalties. Coverage may be rescinded for fraud or intentional misrepresentation of a material fact in this application.



Employee Enrollment and Record Form

Federated Life Insurance Company
 Federated Mutual Insurance Company
Attn: Group Health Administration
1929 S. Cedar, Owatonna, MN 55060
Toll Free: (800) 377-9154 Fax: (507) 446-4697

**Please complete this form carefully.
The effective date may be delayed if
vital information is missing.**

Please print in black ink

SECTION 1: EMPLOYEE INFORMATION

Employee's Last Name _____ First Name _____ Middle Initial _____ Single Married Number of dependent children _____

Social Security # _____ Gender M F Date of Birth _____ Height _____ ft. _____ in Weight _____ lbs

Home Street Address _____ City/State/Zip _____

Employer's Name _____ City/State/Zip _____

Job Title _____ Are you an owner or officer? Yes No Date employed full-time (mm/dd/yy) _____ Hours worked per week _____

Are you (the employee) actively working on a full-time basis and receiving a W2 from this employer? Yes No If no longer receiving a wage from this employer, what was your last date of employment? (mm/dd/yy) _____ N/A

How may we contact you if we need more information? Cell Phone () _____ Home phone () _____ Work phone () _____ Best time to call? _____ am/pm (circle one)

SECTION 2: DEPENDENT INFORMATION – List all dependents applying for coverage (Eligible dependents include legal spouse, unmarried children under age 26 or disabled children of any age.)

Spouse's Last Name _____ First Name _____ Middle Initial _____ Date of Marriage _____

Social Security # _____ Gender M F Date of Birth _____ Height _____ ft. _____ in Weight _____ lbs

Dependent Child(ren) Names (First, Middle Initial, Last)	Social Security Number	Date of Birth (mm/dd/yy)	Gender	Relationship to Employee	Resides in your home?
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Natural/adopted child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Natural/adopted child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Natural/adopted child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Natural/adopted child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 3: BENEFIT SELECTION

(The availability of benefits are based on those offered by your employer)

<p>Select Employee Benefits (Choose One):</p> <p><input type="checkbox"/> All coverages offered by employer <input type="checkbox"/> Life, Dental, & Short Term Disability Only (if offered) <input type="checkbox"/> Currently enrolled in COBRA or State Continuation <input type="checkbox"/> No coverage (complete Section 4)</p>	<p>AND</p>	<p>Select Dependent Benefits (Choose One):</p> <p><input type="checkbox"/> Spouse and dependent children <input type="checkbox"/> Spouse only <input type="checkbox"/> Dependent children only <input type="checkbox"/> No coverage (complete Section 4)</p>
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SECTION 4: DECLINING COVERAGE

(Complete if declining coverage for you, your spouse, or your dependent children)

I am declining health coverage for (check all that apply) Myself My Spouse My Children
because I/we are (choose one) Covered Elsewhere. Name of insurer _____
 Other Explain _____

IMPORTANT: DESCRIPTION OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you are otherwise eligible and request enrollment within 30 days after your coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If no additional premium is required for a new dependent, the 30-day enrollment requirement does not apply.

SECTION 5: LIFE INSURANCE BENEFICIARY

(Complete only if applying for life insurance)

Primary Beneficiary:		Contingent Beneficiary(ies):	
Legal Name	Relationship	Legal Name	Relationship
Date of Birth	Address	Legal Name	Relationship

SECTION 6: HEALTH INFORMATION

(Answer each of the following for you, your spouse, and each dependent listed in section 2)

During the *past 5 years*, has any person had, been told they have, or received treatment or follow-up care for:

Circle all that apply and provide details in Sections 7 and 8

1. <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart/Circulatory	High Blood Pressure, High Cholesterol, Stroke, Heart Attack, Angioplasty, Aneurysm, Vascular Disease, By-Pass Surgery, Irregular Heart Beat, Heart Valve Problems, Anemia, Blood Disorder, Other
2. <input type="checkbox"/> Yes <input type="checkbox"/> No	Lung/Respiratory	Allergies, Asthma, Cystic Fibrosis, Emphysema, Sleep Apnea, COPD, Other
3. <input type="checkbox"/> Yes <input type="checkbox"/> No	Intestinal/Endocrine/ Digestive/Liver	Diabetes (Type I or II), Hepatitis, Colitis, Ulcerative Colitis, Pancreatitis, Cirrhosis, Diverticulitis, Hiatal Hernia, Crohn's Disease, Thyroid Disorder, Other
4. <input type="checkbox"/> Yes <input type="checkbox"/> No	Urinary/Kidney	Kidney Stones, Dialysis, Polycystic Kidneys, Infection, Renal Failure, Enlarged Prostate, Other
5. <input type="checkbox"/> Yes <input type="checkbox"/> No	Brain/Nervous	Multiple Sclerosis, Epilepsy, Seizures, Cerebral Palsy, Paralysis, Brain Injury, Other
6. <input type="checkbox"/> Yes <input type="checkbox"/> No	Skeletal/Muscle	Back/Neck Pain, Hernia, Fibromyalgia, Lupus, Muscular Dystrophy, Osteoarthritis, Rheumatoid Arthritis, Joint Replacement, Artificial Limb, Other
7. <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Health	Anxiety, Depression, Alcohol/Drug Abuse, ADD/ADHD, Bipolar, Anorexia/Bulimia, Other
8. <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer/Tumor/Growth	Cancer or Tumor (provide location below), Benign Polyp, Hodgkins, Leukemia, Other
9. <input type="checkbox"/> Yes <input type="checkbox"/> No	Transplant	If transplant complete: Organ _____ Date of Transplant _____ If transplant pending: Organ _____ Date Expected _____
10. <input type="checkbox"/> Yes <input type="checkbox"/> No	Has any person been diagnosed or treated by a physician for AIDS, ARC, or AIDS related condition?	
11a. <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you or an eligible dependent (even if not enrolling for coverage) an expectant parent? If yes, due date is : _____	
11b. <input type="checkbox"/> Yes <input type="checkbox"/> No	Are there previous or current complications, previous or current multiple births, or a C-section expected (Circle all that apply & explain in Sections 7 and 8).	
12. <input type="checkbox"/> Yes <input type="checkbox"/> No	Is any person to be insured currently disabled, hospitalized, on medical leave, or handicapped? (circle all that apply)	
13. <input type="checkbox"/> Yes <input type="checkbox"/> No	Other than #1-12 above has any person received medical advice or treatment for any condition during the past 5 years? If yes, explain in Sections 7 and 8.	
14. <input type="checkbox"/> Yes <input type="checkbox"/> No	Is there any medical condition that will require treatment or surgery in the next 24 months on any person to be insured? If yes, explain in Sections 7 and 8.	
15. <input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco Use: By whom? _____	Type? _____ Start Date? _____ Stop Date? _____
16. <input type="checkbox"/> Yes <input type="checkbox"/> No	Are any of the above conditions or medications currently covered under Medicare, worker's compensation, auto, or liability coverage? (If yes, circle coverage that applies)	List the condition(s): _____

**SECTION 7: Complete for ALL medical conditions circled and/or checked above
(Please use an additional page, if needed)**

Question #	Person's Name	Diagnosis (name of injury or illness)	Treatment Received	Date of Onset	Date of full recovery or "Not yet recovered"

**SECTION 8: MEDICATIONS: Complete for each person applying for coverage
(List ALL medications taken, use an additional page if needed)**

Question #	Person's Name	Medication	Reason Prescribed	# per day	Dosage (mg/gm)	Date first prescribed	Still Prescribed?
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 9: EMPLOYEE AUTHORIZATION AND REPRESENTATION
(Read this section, sign, and date this form even if not enrolling for coverage)**

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Agreement: I represent that I have read or have had read to me the completed form and the above answers are, to the best of my knowledge and belief, complete and true and, together with any supplements thereto, shall be the basis for any certificate of insurance issued and that the insurance company may withdraw the coverage for which I am applying and may consider such coverage as having never been in effect, if any information is substantially incomplete or incorrect.

I hereby enroll (or decline to be enrolled) in group insurance plan(s) through Federated Insurance. With my enrollment, I authorize my employer to deduct from my earnings an amount sufficient for my contribution, if any, toward the group insurance premiums.

Employee's Signature Date Signed Spouse's Signature (if applying for coverage) Date Signed

SERFF Tracking #:

FEMC-128746933

State Tracking #:**Company Tracking #:****State:**

Arkansas

Filing Company:

Federated Mutual Insurance Company

TOI/Sub-TOI:

H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO

Product Name:

Group Health

Project Name/Number:

Qualified Generic Drug 2013/Qualified Generic Drug 2013

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/05/2012
Comments:			
Attachment(s):			
AR Certification of Compliance.pdf			
Readability Certification.pdf			
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	11/05/2012
Bypass Reason:	There are 2 application forms attached to the Form Schedule for approval.		
		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	11/05/2012
Bypass Reason:	NA		
		Item Status:	Status Date:
Satisfied - Item:	Redline Schedule	Approved-Closed	11/05/2012
Comments:	These same changes were made on all three schedule of benefit forms.		
Attachment(s):			
HS 03 03 _01-13 ed._ redline.pdf			



121 East Park Square
P.O. Box 328 • Owatonna, MN 55060
Phone: (507) 455-5200 • 800-533-0472

FEDERATED MUTUAL INSURANCE COMPANY

Owatonna, Minnesota

October 29, 2012

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.

A handwritten signature in black ink that reads "J. Hankerson".

Jeanne Hankerson

2012.10.29 08:30:39 -05'00'

Jeanne H. Hankerson First Vice President – Director of Compliance

October 29, 2012



121 East Park Square
P.O. Box 328 • Owatonna, MN 55060
Phone: (507) 455-5200 • 800-533-0472

FEDERATED MUTUAL INSURANCE COMPANY

READABILITY CERTIFICATION

**for the state of
ARKANSAS**

GH 03 10 (01-12 ed.)
GH 03 11 (01-12 ed.)

To the best of my knowledge and belief, these forms meet the Flesch minimum reading ease score of the Arkansas readability requirements with a combined score of 50.41.

A handwritten signature in black ink that reads "J Hankerson".

Jeanne Hankerson
2012.10.29 08:30:01 -05'00'

Jeanne H Hankerson First Vice President

October 29, 2012

SCHEDULE OF BENEFITS

Effective Date: [January 1, ~~2012~~2013]

Words and phrases appearing in **bold type** have special meaning as set forth in Section VIII – Definitions or below.

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

	Network Provider	Non-Network Provider
Deductible - Individual	[\$3,000 - \$10,000]	[\$3,000 - \$10,000]
Deductible - Family	[\$6,000- \$20,000]	[\$6,000 - \$20,000]
Coinsurance	[0%]	[25%]
Out-of-Pocket Maximum - Individual	[\$3,000 - \$10,000]	[\$5,500 - \$12,500]
Out-of-Pocket Maximum - Family	[\$6,000 - \$20,000]	[\$11,000 - \$25,000]

2. Pre-certification Requirements

See Section I – General Provisions, 16. Pre-certification Requirements for details on the process.

Pre-certification is required for the following services.

- a. **durable medical equipment**;
- b. diagnostic services:
 - i. CAT scan,
 - ii. MRI,
 - iii. PET scan, and
 - iv. sleep studies;
- c. **home health care services**;
- d. **hospice care services**;
- e. **inpatient** treatment in a **hospital**;
- f. **inpatient** stays for maternity services over the minimum duration listed;
- g. **inpatient** or transitional treatment for **chemical dependency** or **mental illness**;
- h. mastectomy;
- i. **nursing facility** services;
- j. **orthotic devices**;
- k. **prescription drugs** on the prior authorization list;
- l. **prosthetic devices**;
- m. rehabilitative services;
- n. **surgeries**;
- o. therapies:
 - i. **physical therapy**,
 - ii. **occupational therapy**,
 - iii. **speech therapy**, and
 - iv. intravenous therapy; and
- p. transplant services.

3. Definitions

a. **Brand name drug**

means drugs having the trademarked name of the drug on the package label that is not a **performance drug** or **specialty drug**.

b. **Coinsurance**

means the amount, calculated using a fixed percentage, paid by a **covered person** for certain **covered expenses**. **Coinsurance** does not carryover from one **calendar year** to the next **calendar year**. **Coinsurance** does not carryover from a prior insurer if the **employer** purchases this **policy** during the **calendar year**.

c. **Copayment**

means a specified dollar amount that a **covered person** is required to pay for certain **covered expenses**. **Copayments** do not apply toward satisfying the **deductible**, **coinsurance** or **out-of-pocket maximum** requirements of the **policy**.

d. **Deductible**

means the amount that must be paid for certain **covered expenses** in a **calendar year** before **we** will begin paying **benefits** in that **calendar year**. **Copayments** do not apply toward satisfying the **deductible**. Expenses that are not **covered expenses** and penalties for failure to follow pre-certification requirements do not apply toward satisfying the **deductible**.

The individual **deductible** is the most each individual **covered person** must pay each **calendar year** before **we** will begin paying **benefits** for that **covered person** in that **calendar year**. However, if the family **deductible** is satisfied the **benefits** will be paid for the **covered employee** and his covered **dependents** even if their individual **deductibles** are not satisfied.

Any amount the **covered person** pays for **covered expenses** in the last three **months** of the previous **calendar year** which are applied to that **calendar year's deductible** will be carried over and applied to the current **deductible**.

If the **employer** purchases this **policy** during the **calendar year**, for **covered persons** that enroll when the **employer's** coverage first becomes effective with **us**, any amount which was applied to the **deductible** for that **covered person** under the **employer's** previous **plan** in that same **calendar year** will be carried over and applied to the **deductible** on the **policy**. The amount of **deductible** carried over from a prior **plan** cannot exceed the amount of the **deductible** on this **plan**.

e. **Generic drug**

means a non-brand name drug that is not a **performance drug** or **specialty drug** which has:

- i. the same active ingredients, strength and dosage form; and
- ii. is determined by the FDA to be therapeutically equivalent to the drug identified in the prescription.

f. **Out-of-pocket Maximum**

means the amount of **deductible** and **coinsurance** that the **covered person** or his family must pay each **calendar year** for **covered expenses** other than **prescription drugs**. **Prescription drug copayments**, expenses that are not **covered expenses** and pre-certification penalties do not apply to the **out-of-pocket maximum**.

The individual **out-of-pocket maximum** is the most each **covered person** must pay each **calendar year** for **deductible** and **coinsurance** for **covered expenses** other than **prescription drugs**. The family **out-of-pocket maximum** is the most each **covered employee** and his covered **dependents** combined must pay each **calendar year** for **deductibles** and **coinsurance** for **covered expenses** other than **prescription drugs**.

g. **Performance drug**

means drugs appearing on a list of **generic drugs** and **brand name drugs** designated for use as **performance drugs**. The list is subject to periodic review and modification. The list is available at www.express-scripts.com.

h. **Qualified Generic Drugs**

means drugs appearing on a list of generic drugs designated for use as a qualified generic drugs. The list is subject to periodic review and modification. The list is available at www.express-scripts.com.

h.i. Specialty drug

means a list of **generic drugs** and **brand name drugs** designated for use as **specialty drugs**. The list is subject to periodic review and modification. The list is available at www.express-scripts.com.

4. Duration and coverage limits

Autism spectrum disorders	For a covered person up to age 18 diagnosed with "autism spectrum disorders" coverage for "applied behavior analysis" therapy is limited to \$50,000 per calendar year .
Hearing aids	Coverage is limited to \$1,400 per ear every 3 years.
Home health care services	Coverage limited to [100 visits] per calendar year for network and non-network providers combined
In vitro fertilization	Coverage is limited to a lifetime maximum of \$15,000.
Manipulative therapy	Maximum of [26 visits] for manipulative therapy and related services are payable in any calendar year .
Mental illness and chemical dependency services	For mental illness and chemical dependency services combined, maximum benefit of [\$2,500] per calendar year for outpatient services and [\$50,000] per calendar year for inpatient and transitional treatment combined. Lifetime maximum of [\$100,000] for all mental illness and chemical dependency services. If the employer has more than 50 employees these sublimits do not apply. These sublimits do not apply to serious mental illness or biologically based mental illness .
Nursing facility charges	Maximum of [60 days] per confinement with a total of [60 days] per illness or injury .
Prescription Drugs	Maximum dispensing limits have been set on some prescription drugs . Consult your pharmacy for details. 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 brand name drug copayment plus the difference in cost between the brand name drug and the generic drug . Specialty drugs obtained from sources other than the specialty drug network provider are subject to non-network specialty drug copayments plus the amount charged in excess of the network cost of the drug. Specialty drugs obtained as an inpatient , from a physician or from a hospital are subject to non-network specialty drug copayments plus the amount charged in excess of the network cost of the drug not deductible and coinsurance like other drugs received from these sources. The cost of prescription drugs in excess of the network cost of the drugs are not covered expenses . Some prescription drugs require prior authorization to be covered. Consult your pharmacy for details.

5. **Benefits for covered expenses** will be paid subject to the following schedule. Refer to Section VI - **Covered Services** for details of what services are covered.

Covered Services	Network Provider	Non-Network Provider
All covered services not listed below	Deductible Coinsurance	Deductible Coinsurance
Emergency care services	Deductible Coinsurance	Deductible Coinsurance For an emergency condition , the network provider deductible and coinsurance apply.
Preventive care services	Services paid at 100%	Deductible Coinsurance
Annual physical	Benefit limited to [\$500 - \$1,000] per calendar year .	Deductible Coinsurance Benefit limited to [\$250 - \$500] per calendar year .
Qualified Generic Drugs	Copayment of [\$0 - \$25 / 31 day] supply	Copayment of [\$0 - \$25 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Generic drugs	Deductible then Copayment of [\$0 - \$25 / 31 day] supply	Deductible then Copayment of [\$0 - \$25 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Performance Drugs	Deductible then Copayment of [\$0 - \$60 / 31 day] supply	Deductible then Copayment of [\$0 - \$60 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Brand name drugs	Deductible then Copayment of [\$0 - \$100 / 31 day] supply	Deductible then Copayment of [\$0 - \$100 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Specialty drugs	Deductible then Copayment of [\$0 - \$250 / 31 day] supply	Deductible then Copayment of [\$0 - \$250 / 31 day] supply plus the amount charged in excess of the network cost of the drug
Qualified Generic Drugs –mail order	Copayment of [\$0 - \$50 / 90 day] supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider. If pharmacy agrees to terms and conditions, mail order copayment will apply.
Generic drugs – mail order	Deductible then Copayment of [\$0 - \$70 / 90 day] supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider. If pharmacy agrees to terms and conditions, mail order copayment will apply.
Performance Drugs – mail order	Deductible then Copayment of [\$0 - \$180 / 90 day] supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider. If pharmacy agrees to terms and conditions, mail order copayment will apply.
Brand name drugs – mail order	Deductible then Copayment of [\$0 - \$250 / 90 day] supply	Not available at a retail pharmacy unless the pharmacy agrees in writing to the same terms and conditions as the network provider. If pharmacy agrees to terms and conditions, mail order copayment will apply.
Prescription drugs, other than specialty drugs, received as an inpatient or from a hospital or from a physician's office	Deductible Coinsurance	Deductible Coinsurance