Federated Mutual Insurance Company: 1511

Coverage Period: 01/01/2015– 12/31/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.federatedinsurance.com or by calling 1-877-612-4477.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$5000** person / **$10000** family. Does not apply to network preventive care, network primary, specialist or other practitioner office visits, network emergency room or urgent care visits, or prescription drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For network providers **$6600** person / **$13200** family. For non-network providers **$13200** person / **$26400** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, expenses not covered by the plan, pre-certification penalties.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.federatedinsurance.com /LocateProviders or call 1-877-612-4477** for a list of network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

SBC - MN

Questions: Call 1-877-612-4477 or visit us at www.federatedinsurance.com

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.federatedinsurance.com/Member/SBC or call 1-877-612-4477 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	40% Coinsurance	----------none----------
	Specialist visit	20% Coinsurance	40% Coinsurance	----------none----------
	Other practitioner office visit	20% Coinsurance	40% Coinsurance	----------none----------
	Preventive care/screening/immunization	No Charge	40% Coinsurance	Child health supervision services - No charge.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	40% Coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	Pre-Certification required or penalty of 50% of covered expenses up to $500 per covered service applies.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.federatedinsurance.com	Generic drugs	$16 Copay/Drug for Retail ; $40 Copay/Drug for Mail Order	$16 Copay/Drug for Retail ; $40 Copay/Drug for Mail Order	Covers up to a 31 day supply (retail); 90 day supply (network mail order or if retail pharmacy agrees to same terms as network mail order). At non-network pharmacy you also pay the cost in excess of the network cost of the drug. Additionally for Non-preferred, if a Generic or Preferred brand is available, you also pay the difference in cost between these drugs and the Non-preferred brand.
	Preferred brand drugs	$60 Copay/Drug for Retail ; $150 Copay/Drug for Mail Order	$60 Copay/Drug for Retail ; $150 Copay/Drug for Mail Order	
	Non-preferred brand drugs	$90 Copay/Drug for Retail ; $225 Copay/Drug for Mail Order	$90 Copay/Drug for Retail ; $225 Copay/Drug for Mail Order	
	Specialty drugs	$225 Copay/Drug	$225 Copay/Drug	See list of specialty drugs at www.federatedinsurance.com. At non-network pharmacy you also pay the cost in excess of the network cost of the drug.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	Pre-Certification required or penalty of 50% of covered expenses up to $500 per covered service applies.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you need immediate medical attention	Emergency room services	20% Coinsurance	40% Coinsurance	For emergency condition the network provider benefit will apply.
	Emergency medical transportation	20% Coinsurance	40% Coinsurance	----------none----------
	Urgent care	20% Coinsurance	40% Coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Pre-Certification required or penalty of 50% of covered expenses up to $500 per covered service applies.
	Physician/surgeon fee	20% Coinsurance	40% Coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% Coinsurance	40% Coinsurance	Pre-Certification required for inpatient and transitional treatment or penalty of 50% of covered expenses up to $500 per covered service applies. Primary care visit benefits apply if billed as an office visit.
	Mental/Behavioral health inpatient services	20% Coinsurance	40% Coinsurance	
	Substance use disorder outpatient services	20% Coinsurance	40% Coinsurance	
	Substance use disorder inpatient services	20% Coinsurance	40% Coinsurance	
If you are pregnant	Prenatal and postnatal care	20% Coinsurance	40% Coinsurance	Routine prenatal care - No charge.
	Delivery and all inpatient services	20% Coinsurance	40% Coinsurance	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	Pre-Certification required or penalty of 50% of covered expenses up to $500 per covered service applies. Coverage for up to 120 home health care visits per calendar year. Maximum weekly benefit is weekly cost of skilled-nursing care.
	Rehabilitation services	20% Coinsurance	40% Coinsurance	Pre-Certification required or penalty of 50% of covered expenses up to $500 per covered service applies. Coverage limits per calendar year: 36 cardiac rehabilitation services sessions; 26 manipulative therapy visits.
	Habilitation services	20% Coinsurance	40% Coinsurance	Pre-Certification required or penalty of 50% of covered expenses up to $500 per covered service applies. Coverage limits per calendar year: 26 manipulative therapy limits.
	Skilled-nursing care	20% Coinsurance	40% Coinsurance	Pre-Certification required or penalty of 50% of covered expenses up to $500 per covered service applies. Coverage limited to 50% of semi-private hospital room rate. Confinement must begin within 24 hours of hospital discharge. Coverage limited to 120 days per calendar year.
	Durable medical equipment	20% Coinsurance	40% Coinsurance	Pre-Certification required or penalty of 50% of covered expenses up to $500 per covered service applies. Coverage limited to standard models. Repairs limited to normal wear and tear. Replacement no more often than every 5 years. Replacement batteries not covered.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Hospice service	20% Coinsurance	40% Coinsurance	Pre-Certification required or penalty of 50% of covered expenses up to $500 per covered service applies. Only covered in lieu of admission to hospital.
If your child needs dental or eye care	Eye exam	20% Coinsurance	40% Coinsurance	One examination per calendar year. One low vision examination every 5 years.
	Glasses	20% Coinsurance	40% Coinsurance	One pair of lenses and one frame for lenses per calendar year. Or contact lenses once per calendar year in lieu of eyeglasses.
	Dental check-up	No Charge	No Charge	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

Under certain circumstances benefits for injuries caused by another party may need to be paid by them or repaid to Federated.

- Acupuncture
- Bariatric surgery
- Cosmetic surgery - (Unless reconstructive or port wine stain removal)
- Dental care (Adult)
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care outside US
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care - Maximum of 26 visits per calendar year for manipulative therapy.
- Hearing aids - One hearing aid per ear every 3 years for covered persons 18 or younger
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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-612-4477. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Federated Mutual Insurance Company, Medical Benefits & Services Appeals, PO Box 328, Owatonna, Minnesota 55060 or toll-free at (877) 612-4477; the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Minnesota Department of Commerce, Consumer Protection & Education Division, 85 7th Place East, Suite 500, St. Paul, Minnesota 55101-2198 or at (651) 539-1600 or toll-free (800) 657-3602.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-612-4477.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $1,540
- **Patient pays** $6,000

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$5,000
Copays	$40
Coinsurance	$60
Limits or exclusions	$900
Total	**$6,000**

Note: The maternity example assumes single coverage for the mother only. If you have family coverage that includes the baby these numbers will be different.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,160
- **Patient pays** $2,240

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$2,000
Coinsurance	$200
Limits or exclusions	$40
Total	**$2,240**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.