

SERFF Tracking Number: UHLC-125959050 State: Arkansas  
 Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 41190  
 Company Tracking Number:  
 TOI: HOrg02I Individual Health Organizations - Sub-TOI: HOrg02I.005C Individual - Other  
 Health Maintenance (HMO)  
 Product Name: Conversion Forms  
 Project Name/Number: AR Conversion Forms - HMO/ARConv1219-H

## Filing at a Glance

Company: UnitedHealthcare of Arkansas, Inc.

Product Name: Conversion Forms

SERFF Tr Num: UHLC-125959050 State: ArkansasLH

TOI: HOrg02I Individual Health Organizations - Health Maintenance (HMO)

SERFF Status: Closed

State Tr Num: 41190

Sub-TOI: HOrg02I.005C Individual - Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: Gary Officer

Disposition Date: 01/08/2009

Date Submitted: 12/19/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: AR Conversion Forms - HMO

Status of Filing in Domicile: Pending

Project Number: ARConv1219-H

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: The forms are being submitted to our domiciliary state of Arkansas via this submission.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 01/08/2009

State Status Changed: 01/08/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Submission of AR Conversion Policy, Schedule of Benefits, Individual Conversion Application

Rating information will be submitted under separate cover on or around December 22, 2008.

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## Company and Contact

### Filing Contact Information

Gary Officer, Senior Contract Specialist Gary\_F\_Officer@uhc.com  
 5901 Lincoln Dr (952) 992-5515 [Phone]  
 Edina, MN 55436

### Filing Company Information

UnitedHealthcare of Arkansas, Inc. CoCode: 95446 State of Domicile: Arkansas  
 Plaza West Building Group Code: Company Type: HMO  
 415 North McKinley Street, Suite 300  
 Little Rock, AK 72205 Group Name: State ID Number:  
 (952) 992-7428 ext. [Phone] FEIN Number: 63-1036819  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: \$50 fee for policy and associated forms.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare of Arkansas, Inc.	\$50.00	12/19/2008	24649906

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Rosalind Minor	01/08/2009	01/08/2009

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	12/31/2008	12/31/2008	Gary Officer	01/07/2009	01/07/2009

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## **Disposition**

Disposition Date: 01/08/2009

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Approved	Yes
<b>Supporting Document</b>	Application	Approved	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved	Yes
<b>Supporting Document</b>	Cover Letter	Approved	Yes
<b>Supporting Document</b>	Readability Certification	Approved	Yes
<b>Form (revised)</b>	Conversion Policy - HMO	Approved	Yes
<b>Form</b>	Conversion Policy - HMO	Replaced	Yes
<b>Form</b>	Conversion Schedule of Benefits - HMO	Approved	Yes
<b>Form</b>	Individual Conversion Application - HMO	Approved	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 12/31/2008  
Submitted Date 12/31/2008

Respond By Date

Dear Gary Officer,

This will acknowledge receipt of the captioned filing.

Objection 1

- Conversion Policy - HMO (Form)

Comment: Under the Subrogation and Reimbursement provision, it is stated...."That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us....".

Our statues allow carriers the right to subrogation under ACA 23-79-146. There is no mention of an offset.

Our Legal Department has reviewed case law on this topic. It appears that the subrogation rights of the insurer are limited to the funds recovered by the insured from the third party. In Sereboff v. Mid-Atlantic Medical Services, Inc., the US Supreme Court in 2006 stated that the funds must be specifically identifiable and only considered the funds recovered in the settlement. This would exclude possible future claims.

It is the opinion of our Legal Department that we should follow the Supreme Court ruling and limit subrogation rights to the actual funds paid by the third party tortfeasor.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 01/07/2009  
Submitted Date 01/07/2009

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Dear Rosalind Minor,

**Comments:**

**Response 1**

Comments: January 7, 2009

Ms. Rosalind Minor  
Certified Rate & Form Analyst  
Arkansas Department of Insurance  
1200 West Third Street  
Little Rock, AR 72201-1904

Re: United HealthCare of Arkansas, Inc., NAIC #95446  
December 19, 2008 Filing of Conversion Health Insurance Forms:

- State Tracking Number 41190
- SERFF Tracking Number UHLC-125959050

Dear Ms. Minor:

This is in response to your December 31, 2008 letter containing your objection to the above filing.

As a result of your objection, we have deleted the objectionable language (previously on page 38) from the Subrogation and Reimbursement provision in Section 7: General Legal Provisions of the Conversion Policy form. A copy of the revised Conversion Policy form is enclosed.

Based on this, we trust you will be able to give further consideration to the approval of this submission. Thank you for your cooperation and assistance.

If you have any questions or concerns regarding this submission, please contact me using the information shown below.

Sincerely,  
Gary F. Officer, Sr. Compliance Analyst  
UnitedHealthcare  
Mail Code: MN012-S117  
5901 Lincoln Drive, Edina, MN 55436  
Ph: (952) 992-5515, Fax: (952) 992-5105

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 Email: gary\_f\_officer@uhc.com

**Related Objection 1**

Applies To:

- Conversion Policy - HMO (Form)

Comment:

Under the Subrogation and Reimbursement provision, it is stated...."That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us....".

Our statues allow carriers the right to subrogation under ACA 23-79-146. There is no mention of an offset.

Our Legal Department has reviewed case law on this topic. It appears that the subrogation rights of the insurer are limited to the funds recovered by the insured from the third party. In Sereboff v. Mid-Atlantic Medical Services, Inc., the US Supreme Court in 2006 stated that the funds must be specifically identifiable and only considered the funds recovered in the settlement. This would exclude possible future claims.

It is the opinion of our Legal Department that we should follow the Supreme Court ruling and limit subrogation rights to the actual funds paid by the third party tortfeasor.

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Conversion Policy - HMO	POLCNV. H.08.AR		Policy/Contract/Fraternal Certificate	Initial		45	AR 2008 HMO Conversion Policy 1-7-2009.pdf

**Previous Version**

Conversion Policy - HMO	POLCNV. H.08.AR		Policy/Contract/Fraternal Certificate	Initial		45	AR 2008 HMO
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Conversion  
Policy.pdf



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## Form Schedule

Lead Form Number: POLCNV.H.08.AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	POLCNV.H.08.AR	Policy/Contract/Fraternal Certificate	Conversion Policy - HMO	Initial		45	AR 2008 HMO Conversion Policy 1-7-2009.pdf
Approved	SBN.CONV.CHC.H.08.AR	Schedule Pages	Conversion Schedule of Benefits - HMO	Initial		50	AR 2008 HMO Conversion Schedule of Benefits.pdf
Approved	INDCONVA.PP.H.08.AR	Application/Individual Enrollment Form	Conversion Application - HMO	Initial		45	Ind Conversion Application - HMO.pdf

# Conversion Policy

## [United HealthCare of Arkansas, Inc.]

### Policy

This Policy is a legal document between [United HealthCare of Arkansas, Inc.] and you to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Subscriber's application and payment of the required Premium.

The Policy includes:

- The *Schedule of Benefits*.
- The Subscriber's application.
- Riders.
- Amendments.

### Changes to the Document

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of the Policy. When that happens we will send you a new Policy, Rider or Amendment pages.

No one can make any changes to this Policy unless those changes are in writing.

### Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate this Policy, as permitted by law, without your approval.

On its effective date this Policy replaces and overrules any Policy that we may have previously issued to you. This Policy will in turn be overruled by any Policy we issue to you in the future.

This Policy will take effect on the date that we specify in writing. Coverage under this Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of your location. This Policy will remain in effect as long as the Premium is paid when due, subject to termination of this Policy.

We are delivering the Policy in the State of [Arkansas](#). The Policy is governed by the laws of the State of [Arkansas](#).

**Important: The Benefits in this Policy do not necessarily equal or match those benefits provided in your previous group policy.**

# Introduction to Your Policy

We are pleased to provide you with this Policy. This Policy and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

## How to Use this Document

We encourage you to read your Policy and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this Policy by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 7: General Legal Provisions* to better understand how this Policy and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of the Policy are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your Policy and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this Policy and any summaries provided to you, this Policy will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

## Information about Defined Terms

Because this Policy is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*. You can refer to *Section 8: Defined Terms* as you read this document to have a clearer understanding of your Policy.

When we use the words "we," "us," and "our" in this document, we are referring to [\[United HealthCare of Arkansas, Inc.\]](#) When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 8: Defined Terms*.

## Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your ID card. It will be our pleasure to assist you.

If we fail to provide you with reasonable and adequate service, you should feel free to contact the Arkansas Insurance Department at:

**Arkansas Insurance Department**

**[Consumer Services Division]**

**[1200 West Third Street]**

**[Little Rock, AR 72201-1904]**

**[(800) 852-5494] or [(501) 371-2640]**

# Your Responsibilities

## Be Enrolled and Pay Required Contributions

Benefits are available to you only if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins and Premiums*. To be enrolled with us and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with this Policy, including the eligibility requirements.
- You must qualify as a Subscriber or his or her Dependent as those terms are defined in *Section 8: Defined Terms*.

## Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

## Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

## Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

## Pay Your Share

You must pay a Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

## Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Benefit plan's exclusions.

## Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

## File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or if we refer you to a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

## **Use Your Prior Health Care Coverage**

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Benefit plan for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

# Our Responsibilities

## Determine Benefits

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this Policy, the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in our discretion. In order to receive Benefits, you must cooperate with those service providers.

## Pay for Our Portion of the Cost of Covered Health Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

## Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

## Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

## Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, in our sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this

prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider [by going to [www.myuhc.com](http://www.myuhc.com) or] by calling *Customer Care* at the telephone number on your ID card.

## **Offer Health Education Services to You**

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

## **Conversion Policy Table of Contents**

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# Section 1: Covered Health Services

## Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- Covered Health Services are received while this Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible and Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services and/or any Maximum Policy Benefit).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for notifying us or obtaining prior authorization.

***Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."***

### 1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

### 2. Congenital Heart Disease Surgeries

Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include, but are not limited to, surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels, and hypoplastic left or right heart syndrome.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

We have specific guidelines regarding Benefits for CHD services. Contact us at the telephone number on your ID card for information about these guidelines.

### **3. Diabetes Services - Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care**

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

### **4. Durable Medical Equipment**

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece we have determined is the most cost-effective.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services - Diabetic Self-Management Items*.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

## **5. Emergency Health Services - Outpatient**

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

## **6. Home Health Care**

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

## **7. Hospice Care**

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

## **8. Hospital - Inpatient Stay**

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

- Physician services for anesthesiologists, Emergency room Physicians, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

## **9. Lab, X-Ray and Diagnostics - Outpatient**

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include, but are not limited to:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

## **10. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient**

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

## **11. Ostomy Supplies**

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

## **12. Pharmaceutical Products - Outpatient**

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

### **13. Physician Fees for Surgical and Medical Services**

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

### **14. Physician's Office Services - Sickness and Injury**

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services for Preventive Care provided in a Physician's office are described under *Preventive Care Services*.

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office.

### **15. Pregnancy - Maternity Services**

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

### **16. Preventive Care Services**

Services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Examples of preventive medical care are:

#### **Physician office services:**

- Routine physical examinations.
- Well baby and well child care.

- Immunizations.
- Hearing screening.

**Lab, X-ray or other preventive tests:**

- Screening mammography.
- Screening colonoscopy or sigmoidoscopy.
- Cervical cancer screening.
- Prostate cancer screening.
- Bone mineral density tests.

**17. Prosthetic Devices**

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and noses.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

**18. Reconstructive Procedures**

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. **Coverage is provided for at least a minimum of 48 hours for the Hospital - Inpatient Stay related to the mastectomy.** Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other

Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy related services.

## **19. Rehabilitation Services - Outpatient Therapy and Chiropractic Treatment**

Short-term outpatient rehabilitation services, limited to:

- Physical therapy.
- Occupational therapy.
- Chiropractic Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders.

## **20. Scopic Procedures - Outpatient Diagnostic and Therapeutic**

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

## **21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services**

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for anesthesiologists, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

## **22. Surgery - Outpatient**

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

## **23. Therapeutic Treatments - Outpatient**

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

## 24. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

## 25. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

## Additional Benefits Required By Arkansas Law

### 26. In Vitro Fertilization Services

Covered Health Services for in vitro fertilization services. Cryopreservation, the procedure whereby embryos are frozen for late implantation, will be included as an in vitro fertilization procedure. The coverage will include services performed at:

- A medical facility licensed or certified by the *Arkansas Department of Health*.
- A facility certified by the *Arkansas Department of Health* that conforms to the *American College of Obstetricians and Gynecologists* guidelines for in vitro fertilization clinics.
- A facility certified by the *Arkansas Department of Health* which meets the *American Fertility Society* minimal standards for programs of in vitro fertilization.

### 27. Medical Foods

Coverage for Medical Foods and Low Protein Modified Food Products which are for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism and administered under the direction of a Physician is provided if the cost of the Medical Foods and Low Protein Modified Food Products for an individual or a family with a dependent person or persons exceeds the \$2,400 per year, per person income tax credit. If the cost of these products does not exceed the per person income tax credit, coverage is not provided.

### 28. Musculoskeletal Disorders of the Face, Neck or Head

Diagnosis and treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder, whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. Treatment will also include both surgical and non-surgical procedures. Coverage will be the same as that provided for any other musculoskeletal disorder in the body and will be provided whether prescribed or administered by a Physician or dentist.

### 29. Diabetes Services - Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including, but not limited to:

- Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment*.

- Blood glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.

### **30. Temporomandibular Joint Services**

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies, and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis, and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations, and TMJ implants.

## Section 2: Exclusions and Limitations

### How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

### We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services* or through a Rider to the Policy.

### Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

***Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."***

### A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to Chiropractic Treatment and osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

### B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.

- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
  - Extraction, restoration and replacement of teeth.
  - Medical or surgical treatments of dental conditions.
  - Services to improve dental clinical outcomes.
3. Dental implants, bone grafts, and other implant-related procedures.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

### **C. Devices, Appliances and Prosthetics**

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces.
3. The following items are excluded, even if prescribed by a Physician:
  - Blood pressure cuff/monitor.
  - Enuresis alarm.
  - Home coagulation testing equipment.
  - Non-wearable external defibrillator.
  - Trusses.
  - Ultrasonic nebulizers.
  - Ventricular assist devices.
4. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
5. Oral appliances for snoring.
6. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
7. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

### **D. Drugs**

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.

## **E. Experimental or Investigational or Unproven Services**

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

## **F. Foot Care**

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services - Diabetes Self-Management and Training/Diabetic Eye Examination/Foot Care* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
  - Cleaning and soaking the feet.
  - Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

## **G. Medical Supplies**

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
  - Elastic stockings.
  - Ace bandages.
  - Gauze and dressings.
  - Urinary catheters.

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
- Diabetic supplies for which Benefits are provided as described under *Diabetes Services - Diabetic Self-Management Items* in *Section 1: Covered Health Services*.
- Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.

2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

## **H. Mental Health**

1. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements.
2. Services for the treatment of mental illness or mental health conditions.

## **I. Nutrition**

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
  - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
  - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
2. Enteral feedings, even if the sole source of nutrition. *This exclusion does not apply to Medical Foods for which Benefits are provided as described in Section 1: Covered Health Services.*
3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

## **J. Personal Care, Comfort or Convenience**

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
  - Air conditioners, air purifiers and filters, dehumidifiers.
  - Batteries and battery chargers.
  - Breast pumps.
  - Car seats.
  - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.
  - Electric scooters.
  - Exercise equipment.
  - Home modifications such as elevators, handrails and ramps.
  - Hot tubs.
  - Humidifiers.
  - Jacuzzis.
  - Mattresses.

- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Speech generating devices.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

## **K. Physical Appearance**

1. Cosmetic Procedures. See the definition in *Section 8: Defined Terms*. Examples include:
  - Pharmacological regimens, nutritional procedures or treatments.
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
  - Skin abrasion procedures performed as a treatment for acne.
  - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
  - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
  - Treatment for spider veins.
  - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Breast reduction except as coverage is required by the *Women's Health and Cancer Right's Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.
5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
6. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

## L. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders.
5. Psychosurgery.
6. Sex transformation operations.
7. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
8. Biofeedback.
9. *The following services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ): surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; cranosacral therapy; orthodontics; occlusal adjustment; dental restorations.*
10. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea. *This exclusion does not apply to **Musculoskeletal Disorders of the Face, Neck or Head** for which Benefits are provided as described in **Section 1: Covered Health Services under Additional Benefits Required By Arkansas Law**.*
11. Surgical and non-surgical treatment of obesity.
12. Stand-alone multi-disciplinary smoking cessation programs.

## M. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
  - Has not been actively involved in your medical care prior to ordering the service, or
  - Is not actively involved in your medical care after the service is received.This exclusion does not apply to mammography.
4. Foreign language and sign language interpreters.

## N. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment, *except for **In Vitro Fertilization Services** for which Benefits are provided as described in **Section 1: Covered Health Services***. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. The reversal of voluntary sterilization.
4. Maternity related medical services for Enrolled Dependent children.

### **O. Services Provided under another Plan**

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or mental illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

### **P. Substance Abuse**

1. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements.
2. Services for the treatment substance abuse services and chemical dependency services.

### **Q. Transplants**

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

### **R. Travel**

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion.

### **S. Types of Care**

1. Multi-disciplinary pain management programs provided on an inpatient basis.
2. Custodial Care.
3. Domiciliary care.
4. Private duty nursing. This means nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:
  - No skilled services are identified.
  - Skilled nursing resources are available in the facility.
  - The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

5. Respite care.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

## **T. Vision and Hearing**

1. Purchase cost and fitting charge for eye glasses and contact lenses.
2. Routine vision examinations, including refractive examinations to determine the need for vision correction.
3. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).
4. Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.
5. Eye exercise therapy.
6. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

## **U. All Other Exclusions**

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
  - Required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage or adoption.
  - Related to judicial or administrative proceedings or orders.
  - Conducted for purposes of medical research.
  - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. Charges in excess of Eligible Expenses or in excess of any specified limitation.
7. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. **This exclusion does not apply to cryopreservation services for which Benefits are provided as described under *Vitro Fertilization Services* in *Section 1: Covered Health Services*.**
8. Autopsy.

## Section 3: When Coverage Begins and Premiums

### How to Enroll

Eligible Persons must complete an enrollment form. We will give the necessary forms to you. The Eligible Person must then submit the completed forms to us, along with the required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

### If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of this Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

### Who is Eligible for Coverage

We determine who is eligible to enroll under the Policy and who qualifies as a Dependent.

#### Eligible Person

Eligible Person usually refers to a person who was a subscriber or enrolled dependent under a group policy issued by [\[United HealthCare of Arkansas, Inc.\]](#) and who no longer is eligible for coverage under that group policy. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person and Subscriber, see *Section 8: Defined Terms*.

Eligible Persons must reside within the United States.

#### Dependent

Dependent generally refers to the Subscriber's spouse and children who were enrolled dependents under a group policy issued by [\[United HealthCare of Arkansas, Inc.\]](#) and who no longer is eligible for coverage under that group policy. A Dependent also includes a newborn child, a child placed for adoption and an adopted child when that event occurs after the effective date of this Policy. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

### When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

#### New Eligible Persons and Dependents

Coverage for Eligible Persons and any Dependents who are no longer eligible under the group policy issued by [\[United HealthCare of Arkansas, Inc.\]](#) from which they converted is effective on the date they become ineligible for group coverage. Coverage for Eligible Persons and Dependents whose continuation rights are expiring under a group policy issued by [\[United HealthCare of Arkansas, Inc.\]](#) from which they converted begins on the day following expiration of the continuation period.

## **Adding New Dependents**

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Court or administrative order.

Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption, or court or administrative order. Coverage is effective only if we receive any required Premium and are notified within 90 days of the birth, 60 days of the adoption or placement for adoption, or 31 days of the court or administrative order.

## **Premiums**

All Premiums are payable on a monthly basis, by the Subscriber to us at our offices. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

Premiums shall not be pro-rated based upon the Covered Person's effective date of coverage. A full months' Premium shall be charged for the entire month in which the Covered Person's coverage becomes effective.

## **Grace Period**

A grace period of 30 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 30 day grace period, coverage may be canceled after the 30th day and the Subscriber shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

## **Adjustments to Premiums**

We reserve the right to change the schedule of Premiums at any time. We shall give written notice of any change in Premium to the Subscriber at least 31 days prior to the effective date of the change.

## Section 4: When Coverage Ends

### General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in this Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

### Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

Your coverage ends on the date the Policy ends. That date will be either:

- The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will no longer issue this particular type of individual health plan within the applicable market.
- The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will no longer issue any health benefit plan within the applicable market.

- **You No Longer Reside or Work within the Service Area**

Your coverage ends on the last day of the calendar month in which you no longer reside or work in the Service Area. Coverage will end on the date of that move, even if you do not notify us. The Subscriber must notify us if you move from the Service Area.

- **You Are No Longer Eligible**

Your coverage ends on the last day of the calendar month in which you are no longer eligible to be an Enrolled Dependent. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

Your coverage ends on the last day of the calendar month in which we receive written notice from you instructing us to end your coverage, or the date requested in the notice, if later. The Subscriber is responsible for providing written notice to us to end your coverage.

- **Attainment of the Maximum Policy Benefit**

Your coverage ends on the date of attainment of the Maximum Policy Benefit as described in the *Schedule of Benefits*.

### Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Subscriber that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

You fail to pay the required Premium.

- **Fraud or Intentional Misrepresentation**

Fraud or intentional misrepresentation (the Subscriber knowingly gave us false material information). Examples include false information relating to residence and/or employment within the Service Area and false information relating to another person's eligibility or status as a Dependent.

During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under this Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

### **Coverage for a Disabled Dependent Child**

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if all of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical disability.
- Became so incapacitated prior to the attainment of nineteen years of age.
- Depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask you to furnish us with proof of the medical certification of disability **near** the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency as described above, coverage for that child will end.

### **Reinstatement**

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application to us for coverage under another Policy.

## Section 5: How to File a Claim

### If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable Annual Deductible and for paying any required Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

### If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or if we refer you to a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within 15 months of the date of service, Benefits for that health service will be denied or reduced, in our discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

### Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

### Payment of Benefits

You may not assign your Benefits under the Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Subscriber) for you to reimburse them upon receipt of their bill. We may, however, in our discretion, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.

## Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

### What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

### What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

### How to Appeal a Claim Decision

#### Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.

#### Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or benefit confirmation prior to receiving medical care. If we adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols and standard cost-effectiveness analysis, you may appeal that decision pursuant to this process.

#### How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination or post-service claim determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

#### Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution.

process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits.

## **Appeals Determinations**

### **Pre-service Requests for Benefits and Post-service Claim Appeals**

For procedures associated with urgent requests for Benefits, see Urgent Appeals That Require Immediate Action below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

### **Urgent Appeals that Require Immediate Action**

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

### **Voluntary External Review Program**

After you exhaust the appeal process, if we make a final determination to deny Benefits, you may choose to participate in our voluntary external review program. This program only applies if our decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental or Investigational or Unproven Services.

The external review program is not available if our coverage determinations are based on Benefit exclusions or defined Benefit limits.

Contact us at the telephone number shown on your ID card for more information on the voluntary external review program.

## Section 7: General Legal Provisions

### Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your benefit plan and how it may affect you. We administer the benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We do not decide what care you need or will receive. You and your Physician make those decisions.
- We communicate to you decisions about whether the benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this Policy.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

### Our Relationship with Providers

The relationships between us and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

### Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility including Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

## Statements by Subscribers

All statements made by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made a Subscriber to void the Policy after it has been in force for a period of two years.

## Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

## Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

## Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable Annual Deductible. We do not pass these rebates on to you, nor are they applied to any Annual Deductible or taken into account in determining your Coinsurance.

## Interpretation of Benefits

We have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under this Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in this Policy, including the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations related to this Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of this Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

## **Administrative Services**

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to this Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

## **Amendments to this Policy**

To the extent permitted by law we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate this Policy.

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to this Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Subscriber.
- Riders are effective on the date we specify.
- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

## **Information and Records**

We may use your individually identifiable health information to administer this Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under this Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

## **Examination of Covered Persons**

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

## **Workers' Compensation not Affected**

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

## **Other Coverages**

From time to time, we may request information in advance of any Premium due date of any Covered Person as to whether he or she is covered for similar benefits by another hospital, surgical or medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or by any other plan or program or similar benefits provided for, or available to, such person, pursuant to, or in accordance with the requirements of any statute. In the event similar benefits are available to or provided for the Covered Person in accordance with the requirements of any statute and if the statute does not make coverage under this Policy primary, then coverage under this Policy shall be secondary.

## **Subrogation and Reimbursement**

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Policy, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by us,
  - signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim,
  - responding to requests for information about any accident or injuries,
  - making court appearances, and

- obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate, and your heirs.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

## **Refund of Overpayments**

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

## **Limitation of Action**

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

## **Entire Policy**

The Policy issued to the Subscriber, including the *Schedule of Benefits*, the Subscriber's application, and any Riders and/or Amendments, constitutes the entire Policy.

## Section 8: Defined Terms

**Alternate Facility** - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

**Amendment** - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

**Annual Deductible** - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

**Benefits** - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of this Policy, including the *Schedule of Benefits*, and any attached Riders and/or Amendments.

**Chiropractic Treatment** -the therapeutic application of chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

**Coinsurance** - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

**Congenital Anomaly** - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

**Cosmetic Procedures** - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

**Covered Health Service(s)** - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, mental illness, substance abuse, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

We maintain clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical protocols (as revised from time to time), are available to Covered Persons on [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on [UnitedHealthcareOnline](http://UnitedHealthcareOnline).

**Covered Person** - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this Policy are references to a Covered Person.

**Custodial Care** - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

**Dependent** - the Subscriber's legal spouse, domestic partner or an unmarried dependent child of the Subscriber or the Subscriber's spouse who was previously covered under a group policy issued by [\[United HealthCare of Arkansas, Inc.\]](#) from which you converted.

The term child also includes the following when the event occurs after the effective date of this Policy, subject to the requirements as described under *Adding New Dependents* in *Section 3: When Coverage Begins and Premiums*:

- A newborn child.
- A child placed for adoption.
- A legally adopted child.

To be eligible for coverage under the Policy, a Dependent must reside within the Service Area or reside with a Subscriber who works in the Service Area.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any unmarried dependent child under 19 years of age.
- A Dependent includes an unmarried dependent child who is 19 years of age or older, but less than 25 years of age only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - The child must not be regularly employed on a full-time basis.
  - The child must be a Full-time Student.
  - The child must be primarily dependent upon the Subscriber for support and maintenance.
- A Dependent includes an unmarried dependent child of any age who:
  - Is not able to be self-supporting because of mental or physical disability.
  - Became so incapacitated prior to the attainment of nineteen years of age.
  - Is primarily dependent on the Subscriber for support and maintenance.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

**Designated Facility** - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within the Service Area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

**Designated Physician** - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within the Service Area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

**Durable Medical Equipment** - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

**Eligible Expenses** - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

**Eligible Person** - a person who meets the eligibility requirements specified below. An Eligible Person must reside and/or work within the Service Area. All references to a "subscriber", "dependent", and "enrolled dependent" below are references to a subscriber and/or dependent under the group policy issued by United HealthCare of Arkansas, Inc. from which you converted.

- A subscriber or dependent of a subscriber who was covered under the group policy immediately prior to termination of coverage under that policy.
- The subscriber or dependent of a subscriber whose coverage under the group policy terminated for any reason, including the discontinuance of the group policy in its entirety. However, the subscriber or dependent of the subscriber will not be considered to be an Eligible Person if:
  - the termination of the coverage under the group policy was a result of his or her failure to pay any required premium contribution or
  - the group policy is replaced by similar coverage within 31 days.

An Eligible Person does not include anyone who is:

- Eligible for or covered by federal Medicare coverage.

- Eligible for or covered under any other group health policy or contract providing full coverage. This coverage must provide benefits for all preexisting conditions to be considered full coverage.

**Emergency** - a serious medical condition or symptom resulting from Injury, Sickness or mental illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

**Emergency Health Services** - health care services and supplies necessary for the treatment of an Emergency.

**Enrolled Dependent** - a Dependent who is properly enrolled under the Policy.

**Experimental or Investigational Service(s)** - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

**Full-time Student** - a person who is enrolled in and attending, full-time, a recognized course of study or training at one of the following:

- An accredited high school.
- An accredited college or university.
- A licensed vocational school, technical school, cosmetology school, automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student at the end of the calendar month during which you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If you do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

**Home Health Agency** - a program or organization authorized by law to provide health care services in the home.

**Hospital** - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

**Injury** - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

**Inpatient Rehabilitation Facility** - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

**Inpatient Stay** - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

**Intermittent Care** - skilled nursing care that is provided or needed either:

- Fewer than seven days each week; or
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

**Low Protein Modified Food Product** - a food product specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease (such as phenylketonuria, galactosemia, organic acidemias and disorders of amino acid metabolism) under the direction of a Physician.

**Maximum Policy Benefit** - The maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under this Policy. Refer to the *Schedule of Benefits* for details about how the Maximum Policy Benefit applies.

**Medical Food** - a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

**Medicare** - Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

**Network** - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

**Network Benefits** - The description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* for details about how Network Benefits apply.

**Out-of-Pocket Maximum** - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

**Pharmaceutical Product(s)** - FDA-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

**Physician** - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, audiologist, certified registered nurse anesthetist, dental technician, licensed professional counselor, osteopath, psychological examiner, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

**Per Occurrence Deductible** - The amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

When a Benefit plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.

**Policy** - the entire agreement issued to the Subscriber that includes all of the following:

- This *Policy*.
- The *Schedule of Benefits*.
- The Subscriber's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Subscriber.

**Pregnancy** - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

**Pre-implantation Genetic Diagnosis (PGD)** - a screening test typically performed in conjunction with in vitro fertilization (IVF) in which one or two cells are removed from an embryo to be screened for genetic abnormalities.

**Premium** - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of this Policy.

**Rider** - any attached written description of additional Covered Health Services not described in this Policy. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of this Policy except for those that are specifically amended in the Rider.

**Semi-private Room** - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a

Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

**Service Area** - the geographic area we serve, which has been approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

**Sickness** - physical illness, disease or Pregnancy. The term Sickness as used in this Policy does not include mental illness or substance abuse, regardless of the cause or origin of the mental illness or substance abuse.

**Skilled Nursing Facility** - a Hospital or nursing facility that is licensed and operated as required by law.

**Subscriber** - an Eligible Person who is properly enrolled under this Policy. The Subscriber is the person (who is not a Dependent) to whom this Policy is issued.

**Unproven Service(s)** - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at [www.myuhc.com](http://www.myuhc.com).

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.
- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - If the service is one that requires review by the *U.S. Food and Drug Administration* (FDA), it must be FDA-approved.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
  - At least two studies must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
  - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

**Urgent Care Center** - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

# UnitedHealthcare [Choice]

## [United HealthCare of Arkansas, Inc.]

### Schedule of Benefits

#### Accessing Benefits

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this Schedule of Benefits, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

**Benefits** apply to Covered Health Services that are provided by a Network Physician or other Network provider. Benefits for facility services apply when Covered Health Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or a non-Network anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist. Emergency Health Services and Covered Health Services received at an Urgent Care Center outside your geographic area are always paid as Network Benefits.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a [UnitedHealthcare] Policy. As a result, they may bill you for the entire cost of the services you receive.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you, this *Schedule of Benefits* will control.

**Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.**

#### Pre-service Benefit Confirmation

We require notification before you receive certain Covered Health Services. In general, Network providers are responsible for notifying us before they provide these services to you. There are some Benefits, however, for which you are responsible for notifying us. Services for which you must provide pre-service notification are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

**To notify us, call the telephone number for *Customer Care* on your ID card.**

**Covered Health Services which require pre-service notification:**

- Ambulance - non-emergent air and ground.
- **In vitro fertilization services.**
- **Musculoskeletal disorders of the face, neck or head.**
- Transplants.

As we determine, if one or more alternative health services that meets the definition of a Covered Health Service in the Policy under *Section 8: Defined Terms* are clinically appropriate and equally effective for prevention, diagnosis or treatment of a Sickness, Injury, mental illness, substance abuse or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols. Defined clinical protocols shall be based upon nationally recognized scientific evidence and prevailing medical standards and analysis of cost-effectiveness. After you contact us for pre-service Benefit confirmation, we will identify the Benefit level available to you.

The process and procedures used to define clinical protocols and cost-effectiveness of a health service and a listing of services subject to these provisions (as revised from time to time), are available to Covered Persons on [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

If you request a coverage determination at the time notice is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

## Care Coordination<sup>SM</sup>

When we are notified as required, we will work with you to implement the Care Coordination<sup>SM</sup> process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

## Benefits

Annual Deductibles, if applicable, are calculated on a calendar year basis.

Out-of-Pocket Maximums, if applicable, are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
<b>Annual Deductible</b>	
<p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits.</p> <p>Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the Schedule of Benefits table.</p> <p>The Annual Deductible does not include any applicable Per Occurrence Deductible.</p>	<p>[\$0 - 7,500] per Covered Person.</p>
<b>Per Occurrence Deductible</b>	
<p>The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services.</p> <p>You are responsible for paying the lesser of the following:</p> <ul style="list-style-type: none"> <li>• The applicable Per Occurrence Deductible.</li> <li>• The Eligible Expense.</li> </ul>	<p>CHD surgery - Inpatient Stay: [\$100 - 2,000] per Inpatient Stay.</p> <p>Hospital - Inpatient Stay: [\$100 - 2,000] per Inpatient Stay.</p> <p>Surgery - Outpatient: [\$10 - 1,000] per date of service.</p> <p>Transplant - Inpatient Stay: [\$100 - 2,000] per Inpatient Stay.</p>

<b>Out-of-Pocket Maximum</b>	
No Out-of-Pocket Maximum	No Out-of-Pocket Maximum
<b>Maximum Policy Benefit</b>	
The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Policy.	[\$50,000 - 1,000,000] per Covered Person.
<b>Coinsurance</b>	
<p>Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.</p> <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	

## Benefit Limits

This Benefit plan does not have Benefit limits in addition to those stated below within the Covered Health Service categories in the *Schedule of Benefits* table.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<b>1. Ambulance Services</b>			
<b>Pre-service Notification Requirement</b>			
In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must notify us as soon as possible prior to transport. If you fail to notify us as required, you will be responsible for paying all charges and no Benefits will be paid.			
<b>Emergency Ambulance</b> Ground ambulance limited to \$500 per year.  Air ambulance limited to \$1,000 per year.	<i>Ground Ambulance:</i> [50 - 100]%  <i>Air Ambulance:</i> [50 - 100]%	Not Applicable  Not Applicable	Yes  Yes
<b>Non-Emergency Ambulance</b> Ground or air ambulance, as we determine appropriate.	<i>Ground Ambulance:</i> [50 - 100]%  <i>Air Ambulance:</i> [50 - 100]%	Not Applicable  Not Applicable	Yes  Yes
<b>2. Congenital Heart Disease Surgeries</b>			
Benefits under this section include only the Congenital Heart Disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .	[50 - 100]%	Not Applicable	Yes, after the Per Occurrence Deductible is satisfied
<b>3. Diabetes Services - Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</b>			
Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
<b>4. Durable Medical Equipment</b>			
<p>Limited to \$2,500 in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every three years.</p> <p>You must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.</p>	[50 - 100]%	Not Applicable	Yes
<b>5. Emergency Health Services - Outpatient</b>			
<p>Limited to \$500 per year.</p> <p><b>Note:</b> If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided.</p>	[50-100]%	Not Applicable	Yes
<b>6. Home Health Care</b>			
<p>Limited to 40 visits per year. One visit equals up to four hours of skilled care services.</p> <p>This visit limit does not include any service which is billed only for the administration of intravenous infusion.</p>	[50 - 100]%	Not Applicable	Yes
<b>7. Hospice Care</b>			
	[50 - 100]%	Not Applicable	Yes
<b>8. Hospital - Inpatient Stay</b>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[50 - 100]%	Not Applicable	Yes, after the Per Occurrence Deductible is satisfied
<b>9. Lab, X-Ray and Diagnostics - Outpatient</b>			
	[50 - 100]%	Not Applicable	Yes
<b>10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</b>			
	[50 - 100]%	Not Applicable	Yes
<b>11. Ostomy Supplies</b>			
Limited to \$2,500 per year.	[50 - 100]%	Not Applicable	Yes
<b>12. Pharmaceutical Products - Outpatient</b>			
	[50 - 100]%	Not Applicable	Yes
<b>13. Physician Fees for Surgical and Medical Services</b>			
	[50 - 100]%	Not Applicable	Yes
<b>14. Physician's Office Services - Sickness and Injury</b>			
	[50 - 100]%	Not Applicable	Yes
<b>15. Pregnancy - Maternity Services</b>			
<p align="center"><b>It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.</b></p>			
	<p>Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> except that an Annual Deductible, if applicable, will not apply for a newborn child whose length of stay in the Hospital is the same as the</p>		



Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<ul style="list-style-type: none"> <li>• 10 visits of speech therapy.</li> <li>• 10 visits of pulmonary rehabilitation therapy.</li> <li>• 10 visits of cardiac rehabilitation therapy.</li> <li>• 10 visits of post-cochlear implant aural therapy.</li> </ul>			
<b>20. Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>			
	[50 - 100]%	Not Applicable	Yes
<b>21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</b>			
Limited to 40 days per year.	[50 - 100]%	Not Applicable	Yes
<b>22. Surgery - Outpatient</b>			
	[50 - 100]%	Not Applicable	Yes, after the Per Occurrence Deductible is satisfied
<b>23. Therapeutic Treatments - Outpatient</b>			
	[50 - 100]%	Not Applicable	Yes
<b>24. Transplantation Services</b>			
<p><b>Pre-service Notification Requirement</b></p> <p>You must notify us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify us and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.</p>			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Benefits.	[50 - 100]%	Not Applicable	Yes, after the Per Occurrence Deductible is satisfied
<b>25. Urgent Care Center Services</b>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Limited to \$[200] per year.	[50 - 100]%	Not Applicable	Yes
<b>Additional Benefits Required By Arkansas Law</b>			
<b>26. In Vitro Fertilization Services</b>			
<p style="text-align: center;"><b>Pre-service Notification Requirement</b></p> <p>You must notify us as soon as the possibility of the need for in vitro fertilization arises. If you fail to notify us as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.</p>			
Limited to a lifetime maximum of \$15,000.	[50 - 100]%	Not Applicable	Yes
<b>27. Medical Foods</b>			
	[50 - 100]%	Not Applicable	Yes
<b>28. Musculoskeletal Disorders of the Face, Neck or Head</b>			
<p style="text-align: center;"><b>Pre-service Notification Requirement</b></p> <p>Depending upon where the Covered Health Service is provided, any applicable notification or authorization requirements will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i> .	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
<b>29. Diabetes Services - Diabetic Self-Management Items</b>			
Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under <i>Durable Medical Equipment</i> .	<p>For diabetes equipment, Benefits will be the same as those stated under <i>Durable Medical Equipment</i>.</p> <p>For diabetes supplies, [50 - 100]%.</p>	Not Applicable	Yes

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<b>30. Temporomandibular Joint Services</b>			
Limited to \$[1,000] per year.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		

## Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. You are not responsible for any difference between Eligible Expenses and the amount the provider bills. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the Policy..

If one or more alternative health services that meets the definition of Covered Health Service in the Policy under *Section 8: Defined Terms* are clinically appropriate and equally effective for prevention, diagnosis or treatment of a Sickness, Injury, mental illness, substance abuse or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols. Defined clinical protocols shall be based upon nationally recognized scientific evidence and prevailing medical standards and analysis of cost-effectiveness.

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated.

## Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

## **Designated Facilities and Other Providers**

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses at our discretion.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

## **Health Services from Non-Network Providers Paid as Network Benefits**

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

## **Limitations on Selection of Providers**

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you fail to use the selected Network Physician, Benefits will not be paid.

## APPLICATION FOR INDIVIDUAL CONVERSION POLICY

**PLEASE PRINT ALL ANSWERS**

**Mail Completed Application and Initial Premium Payment To:**

[UnitedHealthCare, Division: Benefit Services, P.O. Box 22409, Louisville, KY 40252]

**Section 1: Applicant Information**

Name of Former Group Policyholder (Employer)	Group Policy Number	Group Policyholder City & State
Name of Subscriber (Employee) (if different than Applicant)	Current Group Certificate #	Subscriber's Social Security #
Name of Applicant	Relationship to Subscriber	Applicant's Social Security #
Applicant's Address (Street, City, State, Zip)		Daytime Telephone Number

**Section 2: Qualifying Event (Check One)**

Reason for Termination of Group Coverage

- Termination of Employment
  Other (describe) \_\_\_\_\_

Are you or any member of your family currently:

- Eligible for or covered by Medicare.  Yes  No
- Covered by another group plan, policy, contract, or agreement providing benefits for hospital or medical care.  Yes  No
- Covered for similar benefits by another individual policy or under any arrangement of coverage for individuals in a group, whether insured or uninsured; or covered for similar benefits by reason of any state or federal law.  Yes  No
- Covered for any extended benefits under your prior terminated group policy.  Yes  No

If "Yes", give details of other coverage in the table below (use the back of this form if more space is needed).

**Table of Other Coverages**

For (Name of Individual)	Type of Coverage HMO, PPO, Indemnity, Other (please specify)	Individual Annual Deductible	Name of Insurer or Carrier and Telephone Number or Address
		\$	
		\$	
		\$	
		\$	

Coverage Provided by United HealthCare of Arkansas, Inc.

**Section 3: Plan Election and Premium Rate(s)**

Select the Individual Conversion Plan for which you are applying:

Choice HMO Conversion Plan

Complete the information below for all eligible members of Applicant's family for whom Conversion coverage is requested. Please include all the family members who were covered under the previous Group Coverage but only those family members.

**MONTHLY PREMIUM COMPUTATION**

List monthly premium amount for each person to be covered, including each child.

Names of current Covered Family Members (Print full name)	Date of Birth Mo. Day Yr.	Sex M F	Relationship To Applicant	Currently covered under Group Coverage?	
<b>APPLICANT</b>			xxx	Yes	\$
				<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	\$

Total Premium: This amount is the premium for the initial month of coverage and must accompany this Application. Check or money order (payable to United HealthCare) if accepted, will be accepted subject to collection.

\$

**Section 4: Authorization**

I authorize United HealthCare of Arkansas, Inc. and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted diseases and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurers or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand the purpose of these disclosures and use of my information is to allow UnitedHealthcare and Affiliates to make decisions regarding eligibility and enrollment. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

Please maintain a copy of this authorization for your records.

I hereby request UnitedHealthcare and Affiliates, on the basis of the foregoing statement and answers, to provide me with an Individual Conversion Policy as indicated in this application. It is agreed that: (1) No Agent or any other person except an Officer of UnitedHealthcare and Affiliates has the power to make, modify, or discharge any insurance policy or to bind UnitedHealthcare and Affiliates by making promise respecting benefits under any insurance policy; (2) To the extent that the benefits provided by the Individual Conversion Policy are applied for, coverage hereunder, will replace coverage under the group coverage(s) referred to in this application. The Individual Conversion Policy will become effective, if issued, upon cessation of such group coverage(s).

I understand that I am completing an Individual Conversion Policy application and that each response must be complete and accurate. I request the indicated Individual Conversion coverage for myself and, if the plan provides, for my dependents. I understand that UnitedHealthcare and Affiliates is not bound by any statements I have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments. The information provided on this application is accurate and complete. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

**Signature of Applicant**

**Date**

**To Be Complete by United HealthCare of Arkansas, Inc.**

Coverage Effective Date \_\_\_\_\_  
 Individual Conversion Policy Number \_\_\_\_\_

*SERFF Tracking Number:* UHLC-125959050      *State:* Arkansas  
*Filing Company:* UnitedHealthcare of Arkansas, Inc.      *State Tracking Number:* 41190  
*Company Tracking Number:*  
*TOI:* HOrg02I Individual Health Organizations -      *Sub-TOI:* HOrg02I.005C Individual - Other  
Health Maintenance (HMO)  
*Product Name:* Conversion Forms  
*Project Name/Number:* AR Conversion Forms - HMO/ARConv1219-H

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: UHLC-125959050 State: Arkansas  
Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 41190  
Company Tracking Number:  
TOI: HOrg02I Individual Health Organizations - Sub-TOI: HOrg02I.005C Individual - Other  
Health Maintenance (HMO)  
Product Name: Conversion Forms  
Project Name/Number: AR Conversion Forms - HMO/ARConv1219-H

## Supporting Document Schedules

**Satisfied -Name:** Certification/Notice **Review Status:** Approved 01/08/2009  
**Comments:**  
**Attachment:**  
Certificate of Compliance with Rule & Regulation 19 - HMO.pdf

**Bypassed -Name:** Application **Review Status:** Approved 01/08/2009  
**Bypass Reason:** The application to be used with the submitted policy is also included in the submission for review and approval.  
**Comments:**

**Bypassed -Name:** Health - Actuarial Justification **Review Status:** Approved 01/08/2009  
**Bypass Reason:** Rating information will be sent under separate cover on or about December 22, 2008.  
**Comments:**

**Satisfied -Name:** Cover Letter **Review Status:** Approved 01/08/2009  
**Comments:**  
**Attachment:**  
Cover Letter - HMO.pdf

**Satisfied -Name:** Readability Certification **Review Status:** Approved 01/08/2009  
**Comments:**  
**Attachment:**  
Readability Certification - HMO.pdf

**Certificate of Compliance with  
Arkansas Rule and Regulation 19**

Insurer: United HealthCare of Arkansas, Inc.

Form Number(s): POLCNAV.H.08.AR  
SBN.CONV.CHC.H.08.AR  
INDCONVAPP.H.08.AR

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



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Signature of Company Officer

Forrest G. Burke

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Name

Secretary

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Title

December 19, 2008

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Date

December 19, 2008

Ms. Rosalind Minor  
Certified Rate & Form Analyst  
Arkansas Department of Insurance  
1200 West Third Street  
Little Rock, AR 72201-1904

Re: United HealthCare of Arkansas, Inc., NAIC #95446

**Conversion Health Insurance Filing:**

<u>Form Name</u>	<u>Form Number</u>	<u>Flesch Score</u>
Conversion Policy	POLCNV.H.08.AR	45.2
Conversion Schedule of Benefits	SBN.CONV.CHC.H.08.AR	50.3
Individual Conversion Application	INDCONVAPP.H.08.AR	45.1

Dear Ms. Minor:

On behalf of United HealthCare of Arkansas, Inc., I am submitting the forms listed above for your Department's review and approval. The forms are new and do not replace any form currently in use. The forms will be used with large and small groups located in Arkansas, to provide the conversion privilege required by Arkansas statute.

The above forms are intended for conversion from our Group Major Medical Health Insurance forms:

- form number POL.H.07.AR, et al (approved by your Department on February 26, 2007);
- form number AR2001HPOLICY, et al (approved by your Department on January 10, 2002).

These materials represent final printed format (with the exception of variable text). Once approved, these forms will be used to support the issuance of individual conversion policies offered in your state.

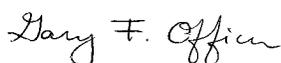
***Explanation of Variable Text:***

The forms are made up of:

- **Nonvariable Text** that always appears in an issued document.
- **Variable Text** allows for variability in the payment structure issued document depending on the specific plan design. Variable text is enclosed in [brackets]. Brackets will not appear in the final policy forms.
- **Mandated Text** appears in green and is included to comply with state requirements. Please note that mandated text will appear as regular black text in the final documents issued to the subscriber.

If you have any questions or concerns regarding this submission, please contact me using the information shown below.

Sincerely,



Gary F. Officer, Sr. Compliance Analyst  
UnitedHealthcare  
Mail Code: MN012-S117  
5901 Lincoln Drive, Edina, MN 55436

Ph: (952) 992-5515, Fax: (952) 992-5105  
Email: gary\_f\_officer@uhc.com

United HealthCare of Arkansas, Inc.  
NAIC #95446

**READABILITY CERTIFICATION**

This is to certify that the accompanying form(s) comply (complies) with your state's readability requirements:

**A. Option Selected**

The form(s) is (are) scored separately for the Flesch reading ease test (except forms entitled by law to be exempt from the requirements of such law). Score(s) for the (each) form(s) is (are) indicated below.

<u>Form</u>	<u>Flesch Score</u>
POLCNV.H.08.AR	45.2
SBN.CONV.CHC.H.08.AR	50.3
INDCONVAPP.H.08.AR	45.1

**B. Test Option Selected**

Test was applied to each entire policy form.

**C. Standards for Certification**

A checked block indicates the standard has been achieved.

- 1. The form text achieves a minimum score of **40** on the Flesch reading ease test in accordance with the option chosen in Section A above.
- 2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)
- 3. The layout and spacing of the policy form(s) separate the paragraphs from each other and from the border of the paper.
- 4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.
- 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the form(s).



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Forrest G. Burke  
Secretary

Date: December 19, 2008

SERFF Tracking Number: UHLC-125959050 State: Arkansas  
 Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 41190  
 Company Tracking Number:  
 TOI: HOrg02I Individual Health Organizations - Sub-TOI: HOrg02I.005C Individual - Other  
 Health Maintenance (HMO)  
 Product Name: Conversion Forms  
 Project Name/Number: AR Conversion Forms - HMO/ARConv1219-H

## Superseded Attachments

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

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Conversion Policy - HMO	12/19/2008	AR 2008 HMO Conversion Policy.pdf

# Conversion Policy

## [United HealthCare of Arkansas, Inc.]

### Policy

This Policy is a legal document between [United HealthCare of Arkansas, Inc.] and you to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Subscriber's application and payment of the required Premium.

The Policy includes:

- The *Schedule of Benefits*.
- The Subscriber's application.
- Riders.
- Amendments.

### Changes to the Document

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of the Policy. When that happens we will send you a new Policy, Rider or Amendment pages.

No one can make any changes to this Policy unless those changes are in writing.

### Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate this Policy, as permitted by law, without your approval.

On its effective date this Policy replaces and overrules any Policy that we may have previously issued to you. This Policy will in turn be overruled by any Policy we issue to you in the future.

This Policy will take effect on the date that we specify in writing. Coverage under this Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of your location. This Policy will remain in effect as long as the Premium is paid when due, subject to termination of this Policy.

We are delivering the Policy in the State of [Arkansas](#). The Policy is governed by the laws of the State of [Arkansas](#).

**Important: The Benefits in this Policy do not necessarily equal or match those benefits provided in your previous group policy.**

# Introduction to Your Policy

We are pleased to provide you with this Policy. This Policy and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

## How to Use this Document

We encourage you to read your Policy and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this Policy by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 7: General Legal Provisions* to better understand how this Policy and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of the Policy are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your Policy and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this Policy and any summaries provided to you, this Policy will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

## Information about Defined Terms

Because this Policy is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*. You can refer to *Section 8: Defined Terms* as you read this document to have a clearer understanding of your Policy.

When we use the words "we," "us," and "our" in this document, we are referring to [\[United HealthCare of Arkansas, Inc.\]](#) When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 8: Defined Terms*.

## Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your ID card. It will be our pleasure to assist you.

If we fail to provide you with reasonable and adequate service, you should feel free to contact the Arkansas Insurance Department at:

**Arkansas Insurance Department**

**[Consumer Services Division]**

**[1200 West Third Street]**

**[Little Rock, AR 72201-1904]**

**[(800) 852-5494] or [(501) 371-2640]**

# Your Responsibilities

## Be Enrolled and Pay Required Contributions

Benefits are available to you only if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins and Premiums*. To be enrolled with us and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with this Policy, including the eligibility requirements.
- You must qualify as a Subscriber or his or her Dependent as those terms are defined in *Section 8: Defined Terms*.

## Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

## Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

## Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

## Pay Your Share

You must pay a Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

## Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Benefit plan's exclusions.

## Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

## File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or if we refer you to a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

## **Use Your Prior Health Care Coverage**

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Benefit plan for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

# Our Responsibilities

## Determine Benefits

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this Policy, the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in our discretion. In order to receive Benefits, you must cooperate with those service providers.

## Pay for Our Portion of the Cost of Covered Health Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

## Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

## Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

## Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, in our sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this

prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider [by going to [www.myuhc.com](http://www.myuhc.com) or] by calling *Customer Care* at the telephone number on your ID card.

## **Offer Health Education Services to You**

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

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# Section 1: Covered Health Services

## Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- Covered Health Services are received while this Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible and Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services and/or any Maximum Policy Benefit).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for notifying us or obtaining prior authorization.

***Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."***

### 1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

### 2. Congenital Heart Disease Surgeries

Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include, but are not limited to, surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels, and hypoplastic left or right heart syndrome.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

We have specific guidelines regarding Benefits for CHD services. Contact us at the telephone number on your ID card for information about these guidelines.

### **3. Diabetes Services - Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care**

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

### **4. Durable Medical Equipment**

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece we have determined is the most cost-effective.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services - Diabetic Self-Management Items*.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

## **5. Emergency Health Services - Outpatient**

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

## **6. Home Health Care**

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

## **7. Hospice Care**

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

## **8. Hospital - Inpatient Stay**

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

- Physician services for anesthesiologists, Emergency room Physicians, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

## **9. Lab, X-Ray and Diagnostics - Outpatient**

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include, but are not limited to:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

## **10. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient**

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

## **11. Ostomy Supplies**

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

## **12. Pharmaceutical Products - Outpatient**

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

### **13. Physician Fees for Surgical and Medical Services**

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

### **14. Physician's Office Services - Sickness and Injury**

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services for Preventive Care provided in a Physician's office are described under *Preventive Care Services*.

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office.

### **15. Pregnancy - Maternity Services**

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

### **16. Preventive Care Services**

Services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Examples of preventive medical care are:

#### **Physician office services:**

- Routine physical examinations.
- Well baby and well child care.

- Immunizations.
- Hearing screening.

**Lab, X-ray or other preventive tests:**

- Screening mammography.
- Screening colonoscopy or sigmoidoscopy.
- Cervical cancer screening.
- Prostate cancer screening.
- Bone mineral density tests.

**17. Prosthetic Devices**

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and noses.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

**18. Reconstructive Procedures**

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. **Coverage is provided for at least a minimum of 48 hours for the Hospital - Inpatient Stay related to the mastectomy.** Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other

Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy related services.

## **19. Rehabilitation Services - Outpatient Therapy and Chiropractic Treatment**

Short-term outpatient rehabilitation services, limited to:

- Physical therapy.
- Occupational therapy.
- Chiropractic Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders.

## **20. Scopic Procedures - Outpatient Diagnostic and Therapeutic**

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

## **21. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services**

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for anesthesiologists, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

## **22. Surgery - Outpatient**

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

## **23. Therapeutic Treatments - Outpatient**

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

## 24. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

## 25. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

## Additional Benefits Required By Arkansas Law

### 26. In Vitro Fertilization Services

Covered Health Services for in vitro fertilization services. Cryopreservation, the procedure whereby embryos are frozen for late implantation, will be included as an in vitro fertilization procedure. The coverage will include services performed at:

- A medical facility licensed or certified by the *Arkansas Department of Health*.
- A facility certified by the *Arkansas Department of Health* that conforms to the *American College of Obstetricians and Gynecologists* guidelines for in vitro fertilization clinics.
- A facility certified by the *Arkansas Department of Health* which meets the *American Fertility Society* minimal standards for programs of in vitro fertilization.

### 27. Medical Foods

Coverage for Medical Foods and Low Protein Modified Food Products which are for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism and administered under the direction of a Physician is provided if the cost of the Medical Foods and Low Protein Modified Food Products for an individual or a family with a dependent person or persons exceeds the \$2,400 per year, per person income tax credit. If the cost of these products does not exceed the per person income tax credit, coverage is not provided.

### 28. Musculoskeletal Disorders of the Face, Neck or Head

Diagnosis and treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder, whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. Treatment will also include both surgical and non-surgical procedures. Coverage will be the same as that provided for any other musculoskeletal disorder in the body and will be provided whether prescribed or administered by a Physician or dentist.

### 29. Diabetes Services - Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including, but not limited to:

- Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment*.

- Blood glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.

### **30. Temporomandibular Joint Services**

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies, and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis, and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations, and TMJ implants.

## Section 2: Exclusions and Limitations

### How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

### We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services* or through a Rider to the Policy.

### Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

***Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."***

### A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to Chiropractic Treatment and osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

### B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.

- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
  - Extraction, restoration and replacement of teeth.
  - Medical or surgical treatments of dental conditions.
  - Services to improve dental clinical outcomes.
3. Dental implants, bone grafts, and other implant-related procedures.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

### **C. Devices, Appliances and Prosthetics**

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces.
3. The following items are excluded, even if prescribed by a Physician:
  - Blood pressure cuff/monitor.
  - Enuresis alarm.
  - Home coagulation testing equipment.
  - Non-wearable external defibrillator.
  - Trusses.
  - Ultrasonic nebulizers.
  - Ventricular assist devices.
4. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
5. Oral appliances for snoring.
6. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
7. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

### **D. Drugs**

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.

## **E. Experimental or Investigational or Unproven Services**

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

## **F. Foot Care**

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services - Diabetes Self-Management and Training/Diabetic Eye Examination/Foot Care* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
  - Cleaning and soaking the feet.
  - Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

## **G. Medical Supplies**

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
  - Elastic stockings.
  - Ace bandages.
  - Gauze and dressings.
  - Urinary catheters.

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
- Diabetic supplies for which Benefits are provided as described under *Diabetes Services - Diabetic Self-Management Items* in *Section 1: Covered Health Services*.
- Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.

2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

## **H. Mental Health**

1. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements.
2. Services for the treatment of mental illness or mental health conditions.

## **I. Nutrition**

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
  - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
  - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
2. Enteral feedings, even if the sole source of nutrition. *This exclusion does not apply to Medical Foods for which Benefits are provided as described in Section 1: Covered Health Services.*
3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

## **J. Personal Care, Comfort or Convenience**

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
  - Air conditioners, air purifiers and filters, dehumidifiers.
  - Batteries and battery chargers.
  - Breast pumps.
  - Car seats.
  - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.
  - Electric scooters.
  - Exercise equipment.
  - Home modifications such as elevators, handrails and ramps.
  - Hot tubs.
  - Humidifiers.
  - Jacuzzis.
  - Mattresses.

- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Speech generating devices.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

## **K. Physical Appearance**

1. Cosmetic Procedures. See the definition in *Section 8: Defined Terms*. Examples include:
  - Pharmacological regimens, nutritional procedures or treatments.
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
  - Skin abrasion procedures performed as a treatment for acne.
  - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
  - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
  - Treatment for spider veins.
  - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Breast reduction except as coverage is required by the *Women's Health and Cancer Right's Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.
5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
6. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

## L. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders.
5. Psychosurgery.
6. Sex transformation operations.
7. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
8. Biofeedback.
9. *The following services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ): surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; cranosacral therapy; orthodontics; occlusal adjustment; dental restorations.*
10. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea. *This exclusion does not apply to **Musculoskeletal Disorders of the Face, Neck or Head** for which Benefits are provided as described in **Section 1: Covered Health Services under Additional Benefits Required By Arkansas Law**.*
11. Surgical and non-surgical treatment of obesity.
12. Stand-alone multi-disciplinary smoking cessation programs.

## M. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
  - Has not been actively involved in your medical care prior to ordering the service, or
  - Is not actively involved in your medical care after the service is received.This exclusion does not apply to mammography.
4. Foreign language and sign language interpreters.

## N. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment, *except for **In Vitro Fertilization Services** for which Benefits are provided as described in **Section 1: Covered Health Services***. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. The reversal of voluntary sterilization.
4. Maternity related medical services for Enrolled Dependent children.

### **O. Services Provided under another Plan**

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or mental illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

### **P. Substance Abuse**

1. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements.
2. Services for the treatment substance abuse services and chemical dependency services.

### **Q. Transplants**

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

### **R. Travel**

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion.

### **S. Types of Care**

1. Multi-disciplinary pain management programs provided on an inpatient basis.
2. Custodial Care.
3. Domiciliary care.
4. Private duty nursing. This means nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:
  - No skilled services are identified.
  - Skilled nursing resources are available in the facility.
  - The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

5. Respite care.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

## **T. Vision and Hearing**

1. Purchase cost and fitting charge for eye glasses and contact lenses.
2. Routine vision examinations, including refractive examinations to determine the need for vision correction.
3. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).
4. Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.
5. Eye exercise therapy.
6. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

## **U. All Other Exclusions**

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
  - Required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage or adoption.
  - Related to judicial or administrative proceedings or orders.
  - Conducted for purposes of medical research.
  - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. Charges in excess of Eligible Expenses or in excess of any specified limitation.
7. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. **This exclusion does not apply to cryopreservation services for which Benefits are provided as described under *Vitro Fertilization Services* in *Section 1: Covered Health Services*.**
8. Autopsy.

## Section 3: When Coverage Begins and Premiums

### How to Enroll

Eligible Persons must complete an enrollment form. We will give the necessary forms to you. The Eligible Person must then submit the completed forms to us, along with the required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

### If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of this Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

### Who is Eligible for Coverage

We determine who is eligible to enroll under the Policy and who qualifies as a Dependent.

#### Eligible Person

Eligible Person usually refers to a person who was a subscriber or enrolled dependent under a group policy issued by [\[United HealthCare of Arkansas, Inc.\]](#) and who no longer is eligible for coverage under that group policy. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person and Subscriber, see *Section 8: Defined Terms*.

Eligible Persons must reside within the United States.

#### Dependent

Dependent generally refers to the Subscriber's spouse and children who were enrolled dependents under a group policy issued by [\[United HealthCare of Arkansas, Inc.\]](#) and who no longer is eligible for coverage under that group policy. A Dependent also includes a newborn child, a child placed for adoption and an adopted child when that event occurs after the effective date of this Policy. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

### When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

#### New Eligible Persons and Dependents

Coverage for Eligible Persons and any Dependents who are no longer eligible under the group policy issued by [\[United HealthCare of Arkansas, Inc.\]](#) from which they converted is effective on the date they become ineligible for group coverage. Coverage for Eligible Persons and Dependents whose continuation rights are expiring under a group policy issued by [\[United HealthCare of Arkansas, Inc.\]](#) from which they converted begins on the day following expiration of the continuation period.

## **Adding New Dependents**

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Court or administrative order.

Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption, or court or administrative order. Coverage is effective only if we receive any required Premium and are notified within 90 days of the birth, 60 days of the adoption or placement for adoption, or 31 days of the court or administrative order.

## **Premiums**

All Premiums are payable on a monthly basis, by the Subscriber to us at our offices. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

Premiums shall not be pro-rated based upon the Covered Person's effective date of coverage. A full months' Premium shall be charged for the entire month in which the Covered Person's coverage becomes effective.

## **Grace Period**

A grace period of 30 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 30 day grace period, coverage may be canceled after the 30th day and the Subscriber shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

## **Adjustments to Premiums**

We reserve the right to change the schedule of Premiums at any time. We shall give written notice of any change in Premium to the Subscriber at least 31 days prior to the effective date of the change.

## Section 4: When Coverage Ends

### General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in this Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

### Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

Your coverage ends on the date the Policy ends. That date will be either:

- The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will no longer issue this particular type of individual health plan within the applicable market.
- The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will no longer issue any health benefit plan within the applicable market.

- **You No Longer Reside or Work within the Service Area**

Your coverage ends on the last day of the calendar month in which you no longer reside or work in the Service Area. Coverage will end on the date of that move, even if you do not notify us. The Subscriber must notify us if you move from the Service Area.

- **You Are No Longer Eligible**

Your coverage ends on the last day of the calendar month in which you are no longer eligible to be an Enrolled Dependent. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

Your coverage ends on the last day of the calendar month in which we receive written notice from you instructing us to end your coverage, or the date requested in the notice, if later. The Subscriber is responsible for providing written notice to us to end your coverage.

- **Attainment of the Maximum Policy Benefit**

Your coverage ends on the date of attainment of the Maximum Policy Benefit as described in the *Schedule of Benefits*.

### Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Subscriber that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

You fail to pay the required Premium.

- **Fraud or Intentional Misrepresentation**

Fraud or intentional misrepresentation (the Subscriber knowingly gave us false material information). Examples include false information relating to residence and/or employment within the Service Area and false information relating to another person's eligibility or status as a Dependent.

During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under this Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

### **Coverage for a Disabled Dependent Child**

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if all of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical disability.
- Became so incapacitated prior to the attainment of nineteen years of age.
- Depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask you to furnish us with proof of the medical certification of disability **near** the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency as described above, coverage for that child will end.

### **Reinstatement**

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application to us for coverage under another Policy.

## Section 5: How to File a Claim

### If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable Annual Deductible and for paying any required Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

### If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or if we refer you to a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within 15 months of the date of service, Benefits for that health service will be denied or reduced, in our discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

### Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

### Payment of Benefits

You may not assign your Benefits under the Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Subscriber) for you to reimburse them upon receipt of their bill. We may, however, in our discretion, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.

## Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

### What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

### What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

### How to Appeal a Claim Decision

#### Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.

#### Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or benefit confirmation prior to receiving medical care. If we adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols and standard cost-effectiveness analysis, you may appeal that decision pursuant to this process.

#### How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination or post-service claim determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

### Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution.

process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits.

## **Appeals Determinations**

### **Pre-service Requests for Benefits and Post-service Claim Appeals**

For procedures associated with urgent requests for Benefits, see Urgent Appeals That Require Immediate Action below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

### **Urgent Appeals that Require Immediate Action**

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

### **Voluntary External Review Program**

After you exhaust the appeal process, if we make a final determination to deny Benefits, you may choose to participate in our voluntary external review program. This program only applies if our decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental or Investigational or Unproven Services.

The external review program is not available if our coverage determinations are based on Benefit exclusions or defined Benefit limits.

Contact us at the telephone number shown on your ID card for more information on the voluntary external review program.

## Section 7: General Legal Provisions

### Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your benefit plan and how it may affect you. We administer the benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We do not decide what care you need or will receive. You and your Physician make those decisions.
- We communicate to you decisions about whether the benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this Policy.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

### Our Relationship with Providers

The relationships between us and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

### Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility including Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

## Statements by Subscribers

All statements made by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made a Subscriber to void the Policy after it has been in force for a period of two years.

## Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

## Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

## Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable Annual Deductible. We do not pass these rebates on to you, nor are they applied to any Annual Deductible or taken into account in determining your Coinsurance.

## Interpretation of Benefits

We have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under this Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in this Policy, including the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations related to this Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of this Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

## **Administrative Services**

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to this Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

## **Amendments to this Policy**

To the extent permitted by law we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate this Policy.

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to this Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Subscriber.
- Riders are effective on the date we specify.
- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

## **Information and Records**

We may use your individually identifiable health information to administer this Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under this Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

## **Examination of Covered Persons**

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

## **Workers' Compensation not Affected**

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

## **Other Coverages**

From time to time, we may request information in advance of any Premium due date of any Covered Person as to whether he or she is covered for similar benefits by another hospital, surgical or medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or by any other plan or program or similar benefits provided for, or available to, such person, pursuant to, or in accordance with the requirements of any statute. In the event similar benefits are available to or provided for the Covered Person in accordance with the requirements of any statute and if the statute does not make coverage under this Policy primary, then coverage under this Policy shall be secondary.

## **Subrogation and Reimbursement**

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Policy, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by us,
  - signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim,
  - responding to requests for information about any accident or injuries,
  - making court appearances, and

- obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate, and your heirs.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

## Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

## Limitation of Action

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

## Entire Policy

The Policy issued to the Subscriber, including the *Schedule of Benefits*, the Subscriber's application, and any Riders and/or Amendments, constitutes the entire Policy.

## Section 8: Defined Terms

**Alternate Facility** - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

**Amendment** - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

**Annual Deductible** - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

**Benefits** - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of this Policy, including the *Schedule of Benefits*, and any attached Riders and/or Amendments.

**Chiropractic Treatment** -the therapeutic application of chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

**Coinsurance** - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

**Congenital Anomaly** - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

**Cosmetic Procedures** - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

**Covered Health Service(s)** - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, mental illness, substance abuse, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

We maintain clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical protocols (as revised from time to time), are available to Covered Persons on [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on [UnitedHealthcareOnline](http://UnitedHealthcareOnline).

**Covered Person** - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this Policy are references to a Covered Person.

**Custodial Care** - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

**Dependent** - the Subscriber's legal spouse, domestic partner or an unmarried dependent child of the Subscriber or the Subscriber's spouse who was previously covered under a group policy issued by [\[United HealthCare of Arkansas, Inc.\]](#) from which you converted.

The term child also includes the following when the event occurs after the effective date of this Policy, subject to the requirements as described under *Adding New Dependents* in *Section 3: When Coverage Begins and Premiums*:

- A newborn child.
- A child placed for adoption.
- A legally adopted child.

To be eligible for coverage under the Policy, a Dependent must reside within the Service Area or reside with a Subscriber who works in the Service Area.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any unmarried dependent child under 19 years of age.
- A Dependent includes an unmarried dependent child who is 19 years of age or older, but less than 25 years of age only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - The child must not be regularly employed on a full-time basis.
  - The child must be a Full-time Student.
  - The child must be primarily dependent upon the Subscriber for support and maintenance.
- A Dependent includes an unmarried dependent child of any age who:
  - Is not able to be self-supporting because of mental or physical disability.
  - Became so incapacitated prior to the attainment of nineteen years of age.
  - Is primarily dependent on the Subscriber for support and maintenance.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

**Designated Facility** - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within the Service Area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

**Designated Physician** - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within the Service Area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

**Durable Medical Equipment** - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

**Eligible Expenses** - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

**Eligible Person** - a person who meets the eligibility requirements specified below. An Eligible Person must reside and/or work within the Service Area. All references to a "subscriber", "dependent", and "enrolled dependent" below are references to a subscriber and/or dependent under the group policy issued by United HealthCare of Arkansas, Inc. from which you converted.

- A subscriber or dependent of a subscriber who was covered under the group policy immediately prior to termination of coverage under that policy.
- The subscriber or dependent of a subscriber whose coverage under the group policy terminated for any reason, including the discontinuance of the group policy in its entirety. However, the subscriber or dependent of the subscriber will not be considered to be an Eligible Person if:
  - the termination of the coverage under the group policy was a result of his or her failure to pay any required premium contribution or
  - the group policy is replaced by similar coverage within 31 days.

An Eligible Person does not include anyone who is:

- Eligible for or covered by federal Medicare coverage.

- Eligible for or covered under any other group health policy or contract providing full coverage. This coverage must provide benefits for all preexisting conditions to be considered full coverage.

**Emergency** - a serious medical condition or symptom resulting from Injury, Sickness or mental illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

**Emergency Health Services** - health care services and supplies necessary for the treatment of an Emergency.

**Enrolled Dependent** - a Dependent who is properly enrolled under the Policy.

**Experimental or Investigational Service(s)** - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

**Full-time Student** - a person who is enrolled in and attending, full-time, a recognized course of study or training at one of the following:

- An accredited high school.
- An accredited college or university.
- A licensed vocational school, technical school, cosmetology school, automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student at the end of the calendar month during which you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If you do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

**Home Health Agency** - a program or organization authorized by law to provide health care services in the home.

**Hospital** - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

**Injury** - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

**Inpatient Rehabilitation Facility** - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

**Inpatient Stay** - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

**Intermittent Care** - skilled nursing care that is provided or needed either:

- Fewer than seven days each week; or
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

**Low Protein Modified Food Product** - a food product specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease (such as phenylketonuria, galactosemia, organic acidemias and disorders of amino acid metabolism) under the direction of a Physician.

**Maximum Policy Benefit** - The maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under this Policy. Refer to the *Schedule of Benefits* for details about how the Maximum Policy Benefit applies.

**Medical Food** - a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

**Medicare** - Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

**Network** - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

**Network Benefits** - The description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* for details about how Network Benefits apply.

**Out-of-Pocket Maximum** - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

**Pharmaceutical Product(s)** - FDA-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

**Physician** - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, audiologist, certified registered nurse anesthetist, dental technician, licensed professional counselor, osteopath, psychological examiner, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

**Per Occurrence Deductible** - The amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

When a Benefit plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.

**Policy** - the entire agreement issued to the Subscriber that includes all of the following:

- This *Policy*.
- The *Schedule of Benefits*.
- The Subscriber's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Subscriber.

**Pregnancy** - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

**Pre-implantation Genetic Diagnosis (PGD)** - a screening test typically performed in conjunction with in vitro fertilization (IVF) in which one or two cells are removed from an embryo to be screened for genetic abnormalities.

**Premium** - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of this Policy.

**Rider** - any attached written description of additional Covered Health Services not described in this Policy. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of this Policy except for those that are specifically amended in the Rider.

**Semi-private Room** - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a

Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

**Service Area** - the geographic area we serve, which has been approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

**Sickness** - physical illness, disease or Pregnancy. The term Sickness as used in this Policy does not include mental illness or substance abuse, regardless of the cause or origin of the mental illness or substance abuse.

**Skilled Nursing Facility** - a Hospital or nursing facility that is licensed and operated as required by law.

**Subscriber** - an Eligible Person who is properly enrolled under this Policy. The Subscriber is the person (who is not a Dependent) to whom this Policy is issued.

**Unproven Service(s)** - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at [www.myuhc.com](http://www.myuhc.com).

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.
- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - If the service is one that requires review by the *U.S. Food and Drug Administration* (FDA), it must be FDA-approved.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
  - At least two studies must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
  - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

**Urgent Care Center** - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.