

SERFF Tracking Number: UHLC-126344347 State: Arkansas
Filing Company: United HealthCare Insurance Company State Tracking Number: 43797
Company Tracking Number: 2009AMD.01.AR H&I
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
Product Name: 2009 Amendment to the 2001 Series
Project Name/Number: 2009 Amendment to the 2001 Series/2009 Amendment to the 2001 Series

Filing at a Glance

Company: United HealthCare Insurance Company

Product Name: 2009 Amendment to the 2001 Series SERFF Tr Num: UHLC-126344347 State: Arkansas

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved-Closed State Tr Num: 43797

Sub-TOI: H16G.001C Any Size Group - Other Co Tr Num: 2009AMD.01.AR H&I State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor

Author: Tiffany Sievers Disposition Date: 10/27/2009
Date Submitted: 10/14/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 2009 Amendment to the 2001 Series
Project Number: 2009 Amendment to the 2001 Series
Requested Filing Mode:
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 10/27/2009

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Group Market Type: Employer
Explanation for Other Group Market Type:
State Status Changed: 10/27/2009
Created By: Tiffany Sievers
Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Tiffany Sievers

Filing Description:

2009 Amendment to the 2001 Series

Company and Contact

Filing Contact Information

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Filing Company Information

United HealthCare Insurance Company	CoCode: 79413	State of Domicile: Connecticut
450 Columbus Boulevard	Group Code: 707	Company Type: Life and Health
PO Box 150450	Group Name:	State ID Number:
Hartford, CT 06115-0450	FEIN Number: 36-2739571	
(860) 702-5000 ext. [Phone]		

Filing Fees

Fee Required? Yes
 Fee Amount: \$20.00
 Retaliatory? Yes
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United HealthCare Insurance Company	\$20.00	10/14/2009	31295352

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/27/2009	10/27/2009

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Disposition

Disposition Date: 10/27/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes

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Form Schedule

Lead Form Number: 2009AMD.H.01.AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 10/27/2009	2009AMD.I. 01.NC	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Amendment	Initial		50.800	AR01I_FED_ 2009 AMEND_AM_ CS_Rev1 091509.pdf

2009 Amendment

As described in this Amendment, the Policy is modified as stated below.

Product Design [Para] Note to Contract Issuance: Include only if the Amendment is to be mailed separate from the COC and if the 2001 series is modified by other amendments. Do not include when amendment is issued as part of the COC.

[Because this Amendment reflects changes in requirements of Federal law, to the extent it may conflict with any Amendment issued to you previously, the provisions of this Amendment will govern.]

Because this Amendment is part of a legal document (the group Policy), 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 the Certificate of Coverage (Certificate) in (Section 10: Glossary of Defined Terms) and in this Amendment below.

Section 1: What's Covered--Benefits

Sm.Grp[Para] Include as standard only for groups of 15+.

[The following provision is added to (Section 1: What's Covered--Benefits):]

Product Design [Para] Note to Contract Issuance: The bracketed Covered Health Service number will not be included when the document is issued in amendment format only; including it here supports accurately embedding amendment provisions into the COC where permitted.

[Benefit Information]

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><u>Product Design [Para]</u> ¹Include Network and Non-Network references for Choice Plus, Select Plus and Options PPO; delete references and the Non-Network row for 80-80 and Managed Indemnity.</p> <p>Sm.Grp[Para] Include as standard only for groups of 15+. Mandated Offer for groups with fewer than 15.</p>	<p>¹<u>Network</u> [No]</p>	<p>[[0 - 50] %] ⁴[No Copayment]</p>	<p>[Yes][No]</p>	<p>[Yes]⁴[No]</p>

[#.] [Hearing Aids]

[Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for

<p>¹<u>Non-Network</u> [No]</p>	<p>[[0 - 50] %]</p>	<p>[Yes][No]</p>	<p>[Yes]⁴[No]</p>
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[UnitedHealthcare Insurance Company]

[Description of Covered Health Service]

[Must You Notify Us?]

[Your Copayment Amount]

% Copayments are based on a percent of Eligible Expenses]

[Does Copayment Help Meet Out-of-Pocket Maximum?]

[Do You Need to Meet Annual Deductible?]

the hearing aid and for charges for associated fitting and testing.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in the Certificate, only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.]

Group [Para]	¹ Include when group declines the AR mandatory offer and include the limit selected by the group.
Group [text]	Limit must be the same as annual limits selected for Durable Medical Equipment and Prosthetics, or \$5,000 per year if DME and Prosthetic limits exceed \$5,000 per year
Prdct. Design[text]	² Include for Choice Plus, Select Plus and Options PPO. ³ Include for 80-80, Managed Indemnity.

¹[[²Any combination of Network and Non-Network Benefits for hearing aids is][³Benefits for hearing aids are] limited to \$[2,500 - 5,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [two-five] years.]

Group [Para]	⁴ Include for groups under 15 that accept the mandatory offer. No Copayment or Annual Deductible can be applied.
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⁴Limited to \$1,400 per individual hearing aid, per hearing impaired ear, every three years.]

[⁴No Copayment]

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Group [Para]

Always standard for groups of 51+ , optional for groups of 50 or less. Benefit is only optional for groups of 50 or fewer. Full Parity must be offered to groups of 50 or fewer and rejected in writing. Benefits for Mental Health services, which are not full parity, must be offered to groups with 50 or fewer and rejected in writing. The limits listed below would only be applicable to groups of 50 or fewer who opt for Non-parity benefits. SUD benefits are a mandated offer that must be rejected in writing.

[Mental Health and Substance Abuse Services - Inpatient and Intermediate and Mental Health and Substance Abuse Services - Outpatient in (Section 1: What's Covered -- Benefits) are deleted and replaced with the following Covered Health Service descriptions for Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services and Substance Use Disorder Services.]

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>Product Design [Para] ¹Include Network and Non-Network references for Choice Plus, Select Plus and Options PPO; delete references and the Non-Network row for 80-80 and Managed Indemnity.</p> <p>Group [Para] Include when group purchases plan with MH benefits.</p>	<p><u>Network</u> [You must call the Mental Health/ Substance Use Disorder Designee to receive the Benefits.]</p>	<p><i>[Inpatient and Intermediate]</i> [[0 - 50] %] [\$[100 - 1,000] per day] [\$[100 - 2,000] per Inpatient Stay] [\$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p>	<p>[Yes] [No]</p>	<p>[Not Applicable] [Yes][No]</p>
<p>[#.] [Mental Health Services] [Mental Health Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.</p> <p>Benefits for Mental Health Services include:</p> <ul style="list-style-type: none"> • Mental health evaluations and assessment. • Diagnosis. • Treatment planning. • Referral services. • Medication management. • Inpatient. • Partial Hospitalization/Day Treatment. • Intensive Outpatient Treatment. 		<p><i>[Outpatient]</i> [[0 - 50] %] [\$[5 - 100] per visit] [\$[5 - 75] per individual visit; \$[5 - 75] per group visit.] [No Copayment for visits for</p>	<p>[Yes] [No]</p>	<p>[Not Applicable] [Yes][No]</p>

[UnitedHealthcare Insurance Company]

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<ul style="list-style-type: none"> Services at a Residential Treatment Facility. Individual, family and group therapeutic services. Crisis intervention. 		medication management.]		
<p>Group [Para] ¹For groups not subject to Federal Parity requirements, include benefit conversion information if the group purchases option to convert inpatient days to intermediate care or transitional care. Delete for groups subject to Federal Parity requirements.</p> <p>The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. [¹When limits apply to inpatient or Intermediate Care services, inpatient days may be converted to Intermediate Care (such as Partial Hospitalization/Day Treatment or Intensive Outpatient Treatment programs) or Transitional Care at the discretion of the Mental Health/Substance Use Disorder Designee.</p>	<p>[¹ Non-Network] [You must call the Mental Health/Substance Use Disorder Designee to receive the Benefits.]</p>	<p><i>[Inpatient and Intermediate]</i> [[0 - 50]%] [\$[100 - 1,000] per day] [\$[100 - 2,000] per Inpatient Stay] [\$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p>	[Yes] [No]	[Not Applicable] [Yes][No]
<p>One inpatient day is equivalent to:</p>				
<p>Group [Para] ²Adjust days according to plan parameters (standard is two sessions of partial hospitalization/day treatment; five sessions of intensive outpatient treatment; six outpatient visits; ten days of Transitional Care.</p>		<p><i>[Outpatient]</i> [[0 - 50]%] [\$[5 - 100] per visit] [\$[5 - 75] per individual visit; \$[5 - 75] per group visit.] [No Copayment</p>	[Yes] [No]	[Not Applicable] [Yes][No]
<ul style="list-style-type: none"> One day at a Residential Treatment Facility. [²Two] sessions of Partial Hospitalization/Day Treatment. [²Five] sessions of Intensive Outpatient Treatment. [²Six] outpatient visits. [²Ten] days of Transitional Care.] 				

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>Referrals to a Mental Health Services provider are at the discretion of the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating all of your care.</p> <p>Mental Health Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for Mental Health Services.</p> <p>Special Mental Health Programs and Services</p> <p>Group [Para] ¹Include for non-parity customers. Group [Para] ²Include for parity customers. Group [Para] ³include if applicable.</p> <p>Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Mental Health Services Benefit. ¹Depending on the type of programs or services available, the programs or services may be offered to you at no cost or as an exchange of Benefits. When offered as an exchange of Benefits for use of these programs or services, this exchange is based on the assignment of the program or service to either inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use and any associated Copayment, Coinsurance and deductible.] ²The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment,</p>		<p>for visits for medication management.]</p>		

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
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Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use.] Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care ³or through other pathways as described in the program introductions]. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.]

Group [Para]	Note: When the underlying medical plan does not apply visit or day limits, limits are permitted only for small business (50 and fewer) or for non-ERISA groups that choose to be exempt from Parity requirements. Include the limit selected by the group.
Group [Para]	When parity does not apply, this first set of separate benefit statements and limits can be used. When parity does apply, delete these benefit and limit statements and use the "Same as" provisions further below.
Group [text]	Select from these limit options when limits apply only to Mental Health Services described in this section.
Prdct. Design[text]	¹ Include for Choice Plus, Select Plus and Options PPO. ² Include for 80-80 and Managed Indemnity.

[[¹Any combination of Network and Non-Network Benefits for inpatient/intermediate Mental Health Services is] [²Benefits for inpatient/intermediate Mental Health Services are] limited to [10 - 100] days per year.]

[[¹Any combination of Network and Non-Network Benefits for outpatient Mental Health Services is] [²Benefits for outpatient

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
Mental Health Services are limited to [10 - 100] visits per year.]				
Prdct. Design[text] ¹ Include only for Choice Plus, Select Plus and Options PPO when Network Benefits are not limited, but Non-Network Benefits are limited.				
[¹ Non-Network Benefits for inpatient/intermediate Mental Health Services are limited to [10 - 100] days per year.]				
[¹ Non-Network Benefits for outpatient Mental Health Services are limited to [10 - 100] visits per year.]				
Group [text] Select from these limit options when limits apply to Mental Health Services described in this section combined with Neurobiological Disorders - Autism Spectrum Disorders below.				
Prdct. Design[text] ¹ Include for Choice Plus, Select Plus and Options PPO. ² Include for 0-80, Managed Indemnity.				
[[¹ Any combination of Network and Non-Network Benefits] ² Benefits] for any combination of Mental Health Services described in this section and Neurobiological Disorders - Autism Spectrum Disorders described below [¹ is] [² are] limited as follows:				
<ul style="list-style-type: none"> • [10 - 100] days per year for inpatient/intermediate Mental Health Services and Neurobiological Disorders - Autism Spectrum Disorders. 				
<ul style="list-style-type: none"> • [10 - 100] visits per year for outpatient Mental Health Services and Neurobiological Disorders - Autism Spectrum Disorders.] 				
Group [text] Select from these limit options when limits apply to Mental Health Services described in this section combined with Substance Use Disorder Services below.				
Prdct. Design[text] ¹ Include for Choice Plus, Select Plus and Options PPO. ² Include for 80-80,				

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
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Managed Indemnity.

[[¹Any combination of Network and Non-Network Benefits]
²Benefits] for any combination of Mental Health Services described in this section and Substance Use Disorder Services described below [¹is] [²are] limited as follows:

- [10 - 100] days per year for inpatient/intermediate Mental Health Services and Substance Use Disorder Services.
- [10 - 100] visits per year for outpatient Mental Health Services and Substance Use Disorder Services.]

Group [Para]	When this benefit is purchased, prior authorization will always be required for all products except Indemnity.
Group [text]	¹ Include as standard when parity applies.
Group [text]	² Include applicable reduction in Benefits. When the benefit plan design is to reduce benefits by one-half, insert a number that is one-half of the non-network benefit level (i.e. if the out of network copayment is 20%, the benefit level is 80% and the number to insert here is 40%.)
Group [text]	³ Include as standard when parity does not apply.

[Authorization Required]

[Please remember that you must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Use Disorder Designee. The Mental Health/Substance Use Disorder Designee phone number appears on your ID card.

Without authorization, [¹Benefits will be reduced to [²25 - 50]% of Eligible Expenses] [³you will be responsible for paying all charges

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
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and no Benefits will be paid].]

Group [Para] When parity applies, these benefit statements must be used in lieu of those options available above to assure that cost sharing will always be equal to medical services.
 Prdct. Design[text] ¹Include Network and Non-Network references for Choice Plus, Select Plus and Options PPO; delete references and the Non-Network row for Choice, Select, 80-80, Managed Indemnity and Indemnity.

[¹ Network]

[Same as Physician's Office Services and Hospital - Inpatient Stay.]

Group [Para] Include when outpatient visits for medication management are paid at 100%.
 [Benefits for outpatient visits for medication management will be paid at 100%.]

[¹ Non-Network]

[Same as Physician's Office Services and Hospital - Inpatient Stay.]

Group [Para] Include when outpatient visits for medication management are paid at 100%.
 [Benefits for outpatient visits for medication management will be paid at 100%.]

Product Design [Para] ¹Include Network and Non-Network references for Choice Plus, Select Plus and Options PPO; delete references and the Non-Network row for 80-80, Managed Indemnity.

Group [Para] Include when group purchases plan with MH benefits.

[#.] [Neurobiological Disorders - Autism Spectrum Disorder Services]

[Psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in

[¹ Network]

[You must call the Mental Health/ Substance Use Disorder Designee to receive the Benefits.]

[Inpatient and Intermediate]

[[0 - 50]%]
 [[\$[100 - 1,000] per day]
 [[\$[100 - 2,000] per Inpatient Stay]
 [[\$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]

[Yes] [No]

[Not Applicable]
 [Yes][No]

[Outpatient]
 [[0 - 50]%]

[Yes] [No]

[Not Applicable]

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>daily functioning.</p> <p>This section describes only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories in the Certificate.</p>		<p>[\$[5 - 100] per visit]</p> <p>[\$[5 - 75] per individual visit;</p> <p>[\$[5 - 75] per group visit.]</p> <p>[No Copayment for visits for medication management.]</p>		<p>[Yes][No]</p>
<p>Benefits include:</p> <ul style="list-style-type: none"> • Diagnostic evaluations and assessment. • Treatment planning. • Referral services. • Medication management. • Inpatient/24-hour supervisory care. • Partial Hospitalization/Day Treatment. • Intensive Outpatient Treatment. • Services at a Residential Treatment Facility. • Individual, family, therapeutic group, and provider-based case management services. • Psychotherapy, consultation, and training session for parents and 	<p>¹ <u>Non-Network</u></p> <p>[You must call the Mental Health/ Substance Use Disorder Designee to receive the Benefits.]</p>	<p>[Inpatient and Intermediate]</p> <p>[[0 - 50]%]</p> <p>[\$[100 - 1,000] per day]</p> <p>[\$[100 - 2,000] per Inpatient Stay]</p> <p>[\$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p>[Outpatient]</p> <p>[[0 - 50]%]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Not Applicable]</p> <p>[Yes][No]</p> <p>[Not Applicable]</p>

[UnitedHealthcare Insurance Company]

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>paraprofessional and resource support to family.</p> <ul style="list-style-type: none"> • Crisis intervention. • Transitional Care. <p>Group [Para] Include when expanded services for autism are sold.</p> <p>[Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as Applied Behavioral Analysis (ABA)).]</p>		<p>[\$5 - 100] per visit</p> <p>[\$5 - 75] per individual visit;</p> <p>[\$5 - 75] per group visit.]</p> <p>[No Copayment for visits for medication management.]</p>		<p>[Yes][No]</p>
<p>Autism Spectrum Disorder services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for Neurobiological Disorders - Autism Spectrum Disorder Services.]</p>				
<p>Group [Para] Note: When the underlying medical plan does not apply visit or day limits, limits are permitted only for small business (50 and fewer) or for non-ERISA groups that choose to be exempt from Parity requirements. Include the limit selected by the group.</p>				
<p>Group [Para] When parity does not apply, this first set of separate benefit statements and limits can be used. When parity does apply, delete these benefit and limit statements and use the "Same as" provisions further below.</p>				
<p>Group [text] Select from these limit options when limits apply only to Neurobiological Disorders - Autism Spectrum Disorders described in this section.</p>				
<p>Prdct. Design[text] ¹Include for Choice Plus, Select Plus and Options PPO. ²Include for Choice,</p>				

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
Select, 80-80, Managed Indemnity and Indemnity.				
[[¹ Any combination of Network and Non-Network Benefits for inpatient/intermediate Neurobiological Disorders - Autism Spectrum Disorders is] [² Benefits for inpatient/intermediate Neurobiological Disorders - Autism Spectrum Disorders are] limited to [10 - 100] days per year.]				
[[¹ Any combination of Network and Non-Network Benefits for outpatient Neurobiological Disorders - Autism Spectrum Disorders is] [² Benefits for outpatient Neurobiological Disorders - Autism Spectrum Disorders are] limited to [10 - 100] visits per year.]				
Prdct. Design[text] ¹ Include only for Choice Plus, Select Plus and Options PPO when Network Benefits are not limited, but Non-Network Benefits are limited.				
[[¹ Non-Network Benefits for inpatient/intermediate Neurobiological Disorders - Autism Spectrum Disorders are limited to [10 - 100] days per year.]				
[[¹ Non-Network Benefits for outpatient Neurobiological Disorders - Autism Spectrum Disorders are limited to [10 - 100] visits per year.]				
Group [text] Select from these limit options when limits apply to Neurobiological Disorders - Autism Spectrum Disorders described in this section combined with Mental Health Services above.				
Prdct. Design[text] ¹ Include for Choice Plus, Select Plus and Options PPO. ² Include for Choice, Select, 80-80, Managed Indemnity and Indemnity.				
[[¹ Any combination of Network and Non-Network Benefits] [² Benefits] for any combination of Neurobiological Disorders - Autism Spectrum Disorders described in this section and Mental				

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
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Health Services described above [¹is] [²are] limited as follows:

- [10 - 100] days per year for inpatient/intermediate Neurobiological Disorders - Autism Spectrum Disorders and Mental Health Services.
- [10 - 100] visits per year for outpatient Neurobiological Disorders - Autism Spectrum Disorders and Mental Health Services.]

Group [Para]	When this benefit is purchased, prior authorization will always be required for all products except Indemnity.
Group [text]	¹ Include as standard when parity applies.
Group [text]	² Include applicable reduction in Benefits. When the benefit plan design is to reduce benefits by one-half, insert a number that is one-half of the non-network benefit level (i.e. if the out of network copayment is 20%, the benefit level is 80% and the number to insert here is 40%.)
Group [text]	³ Include as standard when parity does not apply.

[Authorization Required]

[Please remember that you must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Use Disorder Designee. The Mental Health/Substance Use Disorder Designee phone number appears on your ID card.

Without authorization, [¹Benefits will be reduced to [²25 - 50]% of Eligible Expenses] [³you will be responsible for paying all charges and no Benefits will be paid].]

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>Group [Para] When parity applies, these benefit statements must be used in lieu of those options available above to assure that cost sharing will always be equal to medical services.</p> <p>Prdct. Design[text] ¹Include Network and Non-Network references for Choice Plus, Select Plus and Options PPO; delete references and the Non-Network row for 80-80, Managed Indemnity.</p>	<p>[¹ Network]</p> <p>[Same as Physician's Office Services and Hospital - Inpatient Stay.]</p> <p>Group [Para] Include when outpatient visits for medication management are paid at 100%. [Benefits for outpatient visits for medication management will be paid at 100%.]</p> <p>[¹ Non-Network]</p> <p>[Same as Physician's Office Services and Hospital - Inpatient Stay.]</p> <p>Group [Para] Include when outpatient visits for medication management are paid at 100%. [Benefits for outpatient visits for medication management will be paid at 100%.]</p>			
<p>Product Design [Para] ¹Include Network and Non-Network references for Choice Plus, Select Plus and Options PPO; delete references and the Non-Network row for 80-80, Managed Indemnity.</p> <p>Group [Para] Include when group purchases plan with SUD benefits.</p>	<p>[¹ Network]</p> <p>[You must call the Mental Health/ Substance Use Disorder Designee to receive the Benefits.]</p>	<p>[Inpatient and Intermediate [[0 - 50]%] [\$[100 - 1,000] per day] [\$[100 - 2,000] per Inpatient Stay] [\$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p>	<p>[Yes] [No]</p>	<p>[Not Applicable] [Yes][No]</p>
<p>[#.] [Substance Use Disorder Services]</p>				
<p>[Substance Use Disorder Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.</p>				
<p>Benefits for Substance Use Disorder Services include:</p>				
<ul style="list-style-type: none"> Substance Use Disorder and chemical dependency evaluations and assessment. Diagnosis. 		<p>[Outpatient] [[0 - 50]%] [\$[5 - 100] per</p>	<p>[Yes] [No]</p>	<p>[Not Applicable] [Yes][No]</p>

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<ul style="list-style-type: none"> • Treatment planning. • Detoxification (sub-acute/non-medical). • Inpatient. • Partial Hospitalization/Day Treatment. • Intensive Outpatient Treatment. • Services at a Residential Treatment Facility. • Referral services. • Medication management. • Individual, family and group therapeutic services. • Crisis intervention. 		visit] [\$5 - 75] per individual visit; \$[5 - 75] per group visit.] [No Copayment for visits for medication management.]		
<p>Group [text] ¹For groups not subject to Federal Parity requirements, include benefit conversion information if the group purchases option to convert inpatient days to intermediate care or transitional care. Delete for groups subject to Federal Parity requirements.</p> <p>The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. ¹When limits apply to inpatient or Intermediate Care services, inpatient days may be converted to Intermediate Care (such as Partial Hospitalization/Day Treatment or Intensive Outpatient Treatment programs) or Transitional Care at the discretion of the Mental Health/Substance Use Disorder Designee.</p>	<p>¹ <u>Non-Network</u> [You must call the Mental Health/Substance Use Disorder Designee to receive the Benefits.]</p>	<p>[Inpatient and Intermediate] [0 - 50]% \$[100 - 1,000] per day] \$[100 - 2,000] per Inpatient Stay] \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per</p>	<p>[Yes] [No]</p>	<p>[Not Applicable] [Yes][No]</p>

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>One inpatient day is equivalent to:</p> <p>Group [text] ²Adjust days according to plan parameters (standard is two sessions of partial hospitalization/day treatment; five sessions of intensive outpatient treatment; six outpatient visits; ten days of Transitional Care.</p> <ul style="list-style-type: none"> • One day at a Residential Treatment Facility. • [²Two] sessions of Partial Hospitalization/Day Treatment. • [²Five] sessions of Intensive Outpatient Treatment. • [²Six] outpatient visits. • [²Ten] days of Transitional Care.] <p>Referrals to a Substance Use Disorder Services provider are at the discretion of the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating all of your care.</p> <p>Substance Use Disorder Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for Substance Use Disorder Services.</p> <p>Special Substance Use Disorder Programs and Services</p> <p>Group [text] ¹Include for non-parity customers. Group [text] ²Include for parity customers. Group [text] ³Include if applicable.</p> <p>Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Substance Use Disorder Services Benefit.</p>		<p>Inpatient Stay]</p> <p>[<i>Outpatient</i>] [[0 - 50]%] [\$[5 - 100] per visit] [\$[5 - 75] per individual visit; \$[5 - 75] per group visit.] [No Copayment for visits for medication management.]</p>	<p>[Yes] [No]</p>	<p>[Not Applicable] [Yes][No]</p>

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
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¹ Depending on the type of programs or services available, the programs or services may be offered to you at no cost or as an exchange of Benefits. When offered as an exchange of Benefits for use of these programs or services, this exchange is based on the assignment of the program or service to either inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use and any associated Copayment, Coinsurance and deductible.] ² The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use.] Special programs or services provide access to services that are beneficial for the treatment of your Substance Use Disorder which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care ³ or through other pathways as described in the program introductions]. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

Group [Para] Note: When the underlying medical plan does not apply visit or day limits, limits are permitted only for small business (50 and fewer) or for non-ERISA groups that choose to be exempt from Parity requirements. Include the limit selected by the group.

Group [Para] When parity does not apply, this first set of separate benefit statements and limits can be used. When parity does apply, delete these benefit and limit statements and use the "Same as" provisions further below.

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>Group [Para] Select from these limit options when limits apply only to Substance Use Disorder Services described in this section.</p> <p>Prdct. Design[text] ¹Include for Choice Plus, Select Plus and Options PPO. ²Include for Choice, Select, 80-80, Managed Indemnity and Indemnity.</p> <p>[¹Any combination of Network and Non-Network Benefits for inpatient/intermediate Substance Use Disorder Services is] [²Benefits for inpatient/intermediate Substance Use Disorder Services are] limited to [10 - 100] days per year.]</p> <p>[¹Any combination of Network and Non-Network Benefits for outpatient Substance Use Disorder Services is] [²Benefits for outpatient Substance Use Disorder Services are] limited to [10 - 100] visits per year.]</p> <p>Prdct. Design[text] ¹Include only for Choice Plus, Select Plus and Options PPO when Network Benefits are not limited, but Non-Network Benefits are limited.</p> <p>[¹Non-Network Benefits for inpatient/intermediate Substance Use Disorder Services are limited to [10 - 100] days per year.]</p> <p>[¹Non-Network Benefits for outpatient Substance Use Disorder Services are limited to [10 - 100] visits per year.]</p> <p>Group [Para] Select from these limit options when limits apply to Substance Use Disorder Services described in this section combined with Mental Health Services above.</p> <p>Prdct. Design[text] ¹Include for Choice Plus, Select Plus and Options PPO. ²Include for Choice, Select, 80-80, Managed Indemnity and Indemnity.</p> <p>[¹Any combination of Network and Non-Network Benefits] [²Benefits] for any combination of Substance Use Disorder Services described in this section and Mental Health Services described above</p>				

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
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[¹is] [²are] limited as follows:

- [10 - 100] days per year for inpatient/intermediate Mental Health Services and Substance Use Disorder Services.
- [10 - 100] visits per year for outpatient Mental Health Services and Substance Use Disorder Services.]

Group [Para]	When this benefit is purchased, prior authorization will always be required for all products except Indemnity.
Group [text]	¹ Include as standard when parity applies.
Group [text]	² Include applicable reduction in Benefits. When the benefit plan design is to reduce benefits by one-half, insert a number that is one-half of the non-network benefit level (i.e. if the out of network copayment is 20%, the benefit level is 80% and the number to insert here is 40%.)
Group [text]	³ Include as standard when parity does not apply.

[Authorization Required]

[Please remember that you must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Use Disorder Designee. The Mental Health/Substance Use Disorder Designee phone number appears on your ID card.

Without authorization, [¹Benefits will be reduced to [²25 - 50]% of Eligible Expenses] [³you will be responsible for paying all charges and no Benefits will be paid].]

Group [Para]	When parity applies, these benefit statements must be used in lieu of those options available above to assure that cost sharing will always be equal to medical services.
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[¹ Network]

[Same as Physician's Office Services and Hospital - Inpatient Stay.]

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
Prdct. Design[text] ¹ Include Network and Non-Network references for Choice Plus, Select Plus and Options PPO; delete references and the Non-Network row for 80-80, Managed Indemnity.	Group [Para]	Include when outpatient visits for medication management are paid at 100%.	[Benefits for outpatient visits for medication management will be paid at 100%.]	[¹ <u>Non-Network</u>]
				[Same as Physician's Office Services and Hospital - Inpatient Stay.]
	Group [Para]	Include when outpatient visits for medication management are paid at 100%.	[Benefits for outpatient visits for medication management will be paid at 100%.]	

Section 2: What's Not Covered--Exclusions

The exclusion for Mental Health/Substance Abuse in the Certificate under (Section 2: What's Not Covered--Exclusions) is deleted and replaced with the following exclusions for Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services, and Substance Use Disorder Services:

[#.] Mental Health

Group [Para] When group purchases MH coverage, keep exclusions 1-11 and delete exclusion #12. When group does not purchase MH coverage, keep exclusions 10 (except for the text variable) and 12, delete all remaining exclusions.

- [1.] [Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.]
- [2.] [Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.]
- [3.] [Mental Health Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.]
- [4.] [Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.]

- [5.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Use Disorder Designee.]
 - [6.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.]
 - [7.] [Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.]
 - [8.] [Learning, motor skills, and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.]
 - [9.] [Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.]
- Group [text] ¹Delete when group does not purchase benefits.
- [10.] [Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements ¹, unless authorized by the Mental Health/Substance Use Disorder Designee].]
 - [11.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental

Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

The Mental Health/Substance Use Disorder Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.]

Group [Para]	Include when plan does not include MH benefits.
Group [text]	¹ Include when the group provides MH benefits under a separate plan.

[12.][Services for the treatment of mental illness or mental health conditions [¹that the Enrolling Group has elected to provide through a separate benefit plan].]

[#.] Neurobiological Disorders - Autism Spectrum Disorders

Group [Para]	When group purchases autism coverage, keep exclusions 1-10 and delete exclusion #11. When group does not purchase autism coverage, keep exclusions 9 (except for the text variable) and 11, delete all remaining exclusions.
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- [1.] [Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.]
- [2.] [Autism Spectrum Disorder services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.]
- [3.] [Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.]
- [4.] [Mental retardation as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.]
- [5.] [Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.]
- [6.] [Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder.]
- [7.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably

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determined by the Mental Health/Substance Use Disorder Designee.]

Group [Para] Delete when benefits are purchased for expanded autism spectrum disorder.

[8.] [Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder.]

Group [text] ¹Delete when group does not purchase benefits.

[9.] [Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements ¹, unless authorized by the Mental Health/Substance Use Disorder Designee].]

[10.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

The Mental Health/Substance Use Disorder Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.]

Group [Para] Include when plan does not include autism spectrum disorder benefits.

Group [text] ¹Include when the group provides autism spectrum disorder benefits under a separate plan.

[11.] [Services for the treatment of autism spectrum disorders as the primary diagnosis ¹that the Enrolling Group has elected to provide through a separate benefit plan]. (Autism spectrum disorders are a group of neurobiological disorders that includes Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder, and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).)]

[#.] Substance Use Disorders

Group [Para] When group purchases SUD coverage, keep exclusions 1-6 and delete exclusion #7. When group does not purchase SUD coverage, keep exclusions 5 (except for the text variable) and 7, delete all remaining exclusions.

[1.] [Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.]

[2.] [Substance Use Disorder Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.]

[3.] [Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.]

[4.] [Substance Use Disorder Services for the treatment of nicotine or caffeine use.]

Group [text] ¹Delete when group does not purchase benefits.

[5.] [Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar

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arrangements ^[1], unless authorized by the Mental Health/Substance Use Disorder Designee^[1].

[6.] [Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.

Group [text] ¹Include when group purchases MH benefits. ²Include when group does not purchase MH benefits.

- Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's ^[1]Mental Illness^[2] ^[2]mental illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

The Mental Health/Substance Use Disorder Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.]

Group [Para] Include when plan does not include SUD benefits.

Group [text] ¹Include when the group provides SUD benefits under a separate plan.

[7.] [Services for the treatment of substance use disorder services ^[1] that the Enrolling Group has elected to provide through a separate benefit plan].]

Group [Para] Include only if a pre-existing condition exclusion applies to Benefits under the Policy.

[The exclusion for Pre-existing Conditions in the Certificate under (Section 2: What's Not Covered-- Exclusions) is replaced with the following:]

Group [Para] Preexisting Condition Exclusion. Retain exclusion below when group purchases preexisting condition exclusion. Delete entire exclusion when group does not select preexisting condition exclusion.

[#.] [Preexisting Conditions]

Group [Para] This paragraph will be included when group chooses to apply a 12 month preexisting condition exclusion to all Covered Persons.

[1.] [Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months.

This exclusion does not apply to newborn children, newly adopted children or children placed for adoption. This exception for newborn, adopted children and children placed for adoption no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.]

Group [Para] This paragraph will be included when group chooses to apply a 12-month preexisting condition exclusion to "timely adds" and an 18-month preexisting condition exclusion to Late Enrollees.

[1.] [Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following:

- The date you have had Continuous Creditable Coverage for 12 months.
- The date you have had Continuous Creditable Coverage for 18 months if you are a Late Enrollee.

This exclusion does not apply to newborn children, newly adopted children or children placed for adoption. This exception

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for newborn, adopted children and children placed for adoption no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.]

Group [Para] This paragraph will be included when group chooses to apply the preexisting condition exclusion to Late Enrollees only.

Group [text] ¹Select either 12 or 18 month period.

[1.] [Benefits for the treatment of a Preexisting Condition are excluded for Late Enrollees until the date you have had Continuous Creditable Coverage for ¹12] ¹18] months.

This exclusion does not apply to newborn children, newly adopted children or children placed for adoption. This exception for newborn, adopted children and children placed for adoption no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.]

Sm.Grp[Para] Include as standard only for groups of 15+.

[Exclusions for Vision and Hearing in the Certificate under (Section 2: What's Not Covered--Exclusions) are replaced with the following:]

[#.] [Vision and Hearing]

1. Purchase cost of eye glasses or contact lenses.
2. Fitting charge for eye glasses or contact lenses.
3. Eye exercise therapy.
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Group [Para] Include as standard only for groups of 15+.

[5.] [Bone anchored hearing aids except when either of the following applies:

- For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.

- For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy.

Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.]

Group [Para] Include as standard for groups under 15.

[5.] [Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.]

[Section 3: [¹Description of Network and Non-Network Benefits] [²Obtaining Benefits]]

Product Design [Para] Include this section when group purchases MH (including Autism Spectrum Disorders) or SUD services.

Product Design [Para] ¹Include for Choice Plus, Select Plus and Options PPO. ²Include for Choice, Select, Managed Indemnity, 80-80 or Indemnity.

[The provision in the Certificate under (Section 3: [¹Description of Network and Non-Network Benefits]) [²Obtaining Benefits]) describing prior authorization requirements for Mental Health/Substance Abuse Services is replaced with the following:]

Group [Para] Include when group purchases benefits for mental health and/or substance use disorder services and when prior authorization applies to any benefit purchased. ¹Include when MH benefits are sold. ^{1-A}Include when benefits for Neurobiological Disorders - Autism Spectrum Disorders are sold. ²Include when SUD benefits are sold. ³Include when both MH and SUD benefits are sold.

[¹Mental Health Services] [³and] [²Substance Use Disorder Services]

[For [¹Mental Health Services [^{1-A}(including psychiatric services for Autism Spectrum Disorders))] [³and] [²Substance Use Disorder Services], you must obtain prior authorization from the Mental Health/Substance Use Disorder Designee before you receive Covered Health Services. You can contact the Mental Health/Substance Use Disorder Designee at the telephone number on your ID card.

To receive the highest level of Benefits and to avoid incurring the penalties described within each Covered Health Service category, you must call the Mental Health/Substance Use Disorder Designee before obtaining [¹Mental Health Services] [³or] [²Substance Use Disorder Services]. This call starts the utilization review process.

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The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. When you call the Mental Health/Substance Use Disorder Designee as required, you will be

given the names of Network providers who are experienced in addressing your specific problems or concerns.

The Mental Health/Substance Use Disorder Designee performs utilization review to determine whether the requested service is a Covered Health Service. The Mental Health/Substance Use Disorder Designee does not make treatment decisions about the kind of behavioral health care you should or should not receive. You and your provider must make those treatment decisions.]

[To continue reading, go to right column on this page.]

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Section 4: When Coverage Begins

The provision in the Certificate under (Section 4: When Coverage Begins), When to Enroll and When Coverage Begins, Special Enrollment Period is replaced with the following:

When to Enroll	Who Can Enroll	Begin Date
<h3>Special Enrollment Period</h3> <p>An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.</p> <p>An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.</p>	<p>Group [text] ¹Include only if coverage is selected for domestic partners.</p> <p>Group [text] ²Include when group chooses an Open Enrollment Period provision.</p> <p>A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:</p> <ul style="list-style-type: none"> • Birth. • Legal adoption. • Placement for adoption. • Marriage. • [¹Registering a Domestic Partner.] <p>A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period [²or Open Enrollment Period] if the following are true:</p> <ul style="list-style-type: none"> • The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP). 	<p>When an event takes place (for example, a birth, marriage, determination of eligibility for state subsidy), coverage begins on the date of the event if we receive the completed enrollment form and 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 or marriage.</p> <p>For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period [²or Open Enrollment Period] because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.</p>

When to Enroll	Who Can Enroll	Begin Date
	<p>Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.</p> <ul style="list-style-type: none">• The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period [or Open Enrollment Period]; and• Coverage under the prior plan ended because of any of the following:<ul style="list-style-type: none">— Loss of eligibility (including, but not limited to, legal separation, divorce or death).— The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.— In the case of COBRA continuation coverage, the coverage ended.— The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.— The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.— An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.	

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When to Enroll	Who Can Enroll	Begin Date
	<p>— The Eligible Person and/or Dependent loses eligibility under Medicaid or Children's Health Insurance Program (CHIP). Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.</p>	

Section 8: When Coverage Ends

The following provision is added to the Certificate under (Section 8: When Coverage Ends):

Group [text] ¹Include when extended coverage applies only to Full-time Students at a post-secondary school. Delete if extended coverage applies also to high school students.

Extended Coverage for Full-time Students

Coverage for an Enrolled Dependent child who is a Full-time Student [¹at a post-secondary school] and who needs a medically necessary leave of absence will be extended until the earlier of the following:

- One year after the medically necessary leave of absence begins.
- The date coverage would otherwise terminate under the Policy.

Coverage will be extended only when the Enrolled Dependent is covered under the Policy because of Full-time Student status [¹at a post-secondary school] immediately before the medically necessary leave of absence begins and when the Enrolled Dependent's change in Full-time Student status meets all of the following requirements:

- The Enrolled Dependent is suffering from a serious Sickness or Injury.
- The leave of absence [¹from the post-secondary school] is medically necessary, as determined by the Enrolled Dependent's treating Physician.

- The medically necessary leave of absence causes the Enrolled Dependent to lose Full-time Student status for purposes of coverage under the Policy.

A written certification by the treating Physician is required. The certification must state that the Enrolled Dependent child is suffering from a serious Sickness or Injury and that the leave of absence is medically necessary.

For purposes of this extended coverage provision, the term "leave of absence" includes any change in enrollment [¹at the post-secondary school] that causes the loss of Full-time Student status.

Section 10: Glossary of Defined Terms

Group [text] ¹Include when Benefits are provided for either or both MH or SUD Services. ²Include when Benefits are provided for MH Services. ³Include when Benefits are provided for SUD Services. ³Include when Benefits are provided for both MH and SUD Services. ⁴Include when Benefits are not provided for either MH or SUD Services.

The definitions of ¹[Alternate Facility,] Covered Health Services, Experimental or Investigational Service(s), ²[Mental Health Services,] ¹[Mental Health/Substance Abuse Designee,] ²[Mental Illness,] ¹[Primary Physician,] ¹[and] Sickness¹,] ¹[and] ¹[Specialist Physician] ^{1&3}and] ²[Substance Abuse Services] under (Section 10: Glossary of Defined Terms) are deleted and replaced with the following:

Group [Para] Include when Benefits are provided for either MH or SUD Services.
[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.

Group [Para] ¹Include when group purchases MH (including Neurobiological Disorders) or SUD coverage. ²Include when Benefits are provided for MH Services. ³Include when Benefits are provided for SUD Services. ⁴Include when Benefits are provided for both MH and SUD Services.

¹[An Alternate Facility may also provide ²Mental Health Services] ⁴[or] ³[Substance Use Disorder Services] on an outpatient or inpatient basis.]]

Group [Para] ¹Include when group purchases MH (including Neurobiological Disorders). ²Include when group does not purchase MH benefits.

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, ¹Mental Illness,]²mental illness,] substance use disorders, 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 (Section 1: What's Covered -- Benefits) as a Covered Health Service.
- Not otherwise excluded in the Certificate under (Section 2: What's Not Covered -- Exclusions).

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

[UnitedHealthcare Insurance Company]

- "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] or by calling [Member Services] [Customer Service] at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders 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.

Exception:

- **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.

Group [Para] Include when group purchases MH (including Neurobiological Disorders) coverage.

[**Mental Health Services** - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.]

Group [Para] Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

[**Mental Health/Substance Use Disorder Designee** - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.]

Group [Para] Include when group purchases MH (including Neurobiological Disorders) coverage.

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[Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Policy.]

Group [Para] Include definition when Benefits are provided for either MH or SUD Services.
Group [text] ¹Include when group purchases MH (including Neurobiological Disorders) or SUD coverage and all clinicians are considered primary physicians. ²Include when group purchases MH benefits. ³Include when group purchases SUD benefits. ⁴Include when group purchases both MH and SUD benefits. ⁵Include when clinicians providing psychological testing are not considered specialists. Delete #1 entirely when all clinicians are considered specialists.

[Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. [¹For [²Mental Health Services] [⁴and] [³Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Primary Physician [⁵for the provision of all services other than psychological testing].)]

Group [text] ¹Include when group purchases MH benefits (including Neurobiological Disorders). ²Include when group does not purchase MH benefits.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in the Certificate does not include [¹Mental Illness][²mental illness] or substance use disorders, regardless of the cause or origin of the [¹Mental Illness][²mental illness] or substance use disorder.

Group [Para] Include definition when Benefits are provided for either MH or SUD Services.

Group [text] ¹Include when group purchases MH (including Neurobiological Disorders) or SUD coverage and all clinicians are considered specialists.

Group [text] ²Include when group purchases MH (including Neurobiological Disorders) or SUD coverage and only clinicians that perform psychological testing are considered specialists.

Group [text] ³Include when group purchases MH benefits. ⁴Include when group purchases SUD benefits. ⁵Include when group purchases both MH and SUD benefits.

[Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. [¹For [³Mental Health Services] [⁵and] [⁴Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Specialist Physician.] [²For [³Mental Health Services] [⁵and] [⁴Substance Use Disorder Services], a licensed clinician who provides psychological testing is considered on the same basis as a Specialist Physician].]

Group [Para] Include when group purchases SUD benefits.

[Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.]

Group [Para] Include when benefits for MH, Autism or SUD benefits are sold. ¹Include only when benefits for Neurobiological Disorders - Autism Spectrum Disorders are sold.

[The following definitions of [¹ Autism Spectrum Disorders,] Intensive Outpatient Treatment, Intermediate Care, Partial Hospitalization/Day Treatment, Residential Treatment Facility and Transitional Care are added under (Section 10: Glossary of Defined Terms):]

Group [Para] Include when benefits for Neurobiological Disorders - Autism Spectrum Disorders are sold.

[Autism Spectrum Disorders - a group of neurobiological disorders that includes Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder, and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).]

[UnitedHealthcare Insurance Company]

Group [Para] Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.
Group [text] ¹Include when Benefits are provided for MH Services. ²Include when Benefits are provided for SUD Services. ³Include when Benefits are provided for both MH and SUD Services.

[Intensive Outpatient Treatment] - a structured outpatient [¹Mental Health][³or][²Substance Use Disorder] treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.]

Group [Para] Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.
Group [text] ¹Include when Benefits are provided for MH Services. ²Include when Benefits are provided for SUD Services. ³Include when Benefits are provided for both MH and SUD Services.

[Intermediate Care] - [¹Mental Health] [³or] [²Substance Use Disorder] treatment that encompasses the following:

- Care at a Residential Treatment Facility.
- Care at a Partial Hospitalization/Day Treatment program.
- Care through an Intensive Outpatient Treatment program.]

Group [Para] Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

[Partial Hospitalization/Day Treatment] - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.]

Group [Para] Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.
Group [text] ¹Include when Benefits are provided for MH Services. ²Include when Benefits are provided for SUD Services. ³Include when Benefits are provided for both MH and SUD Services.

[Residential Treatment Facility] - a facility which provides a program of effective [¹Mental Health Services] [³or] [²Substance Use Disorder Services] treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.]

Group [Para] Include when group purchases MH (including Neurobiological Disorders) and SUD coverage.

[Transitional Care] - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

Group [Para] Include when group purchases MH (including Neurobiological Disorders) but not SUD coverage.

[***Transitional Care*** - Mental Health Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are supervised living arrangements which are residences that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

Product Design [Para] **Note to Contract Issuance:** Include Effective Date only if Amendment is to be mailed separate from the COC. Do not include effective date when rider is issued as part of the COC. This is a group specific feature and should not be pre-populated during the drafting/filing process.

[Effective Date of this Amendment: _____]

(Name and Title)

SERFF Tracking Number: UHLC-126344347 State: Arkansas
 Filing Company: United HealthCare Insurance Company State Tracking Number: 43797
 Company Tracking Number: 2009AMD.01.AR H&I
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
 Product Name: 2009 Amendment to the 2001 Series
 Project Name/Number: 2009 Amendment to the 2001 Series/2009 Amendment to the 2001 Series

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	10/27/2009
Comments:			
Attachment:			
Cert INS.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	10/27/2009
Bypass Reason:	n/a		
Comments:			

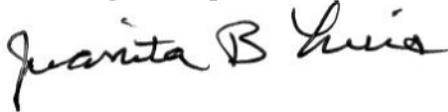
		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved-Closed	10/27/2009
Comments:			
Attachment:			
INS Cover Letter.pdf			

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

Insurer: UnitedHealthcare Insurance Company

Form Number(s): 2009AMD.I.01.AR

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



Signature of Company Officer

Juanita B Luis

Name

Assistant Secretary

Title

October 14, 2009

Date

October 14, 2009

Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Re: UnitedHealthcare Insurance Company
Form No: 2009AMD.H.01.NC

Dear Madam/Sir:

On behalf of UnitedHealthcare Insurance Company, I am submitting the enclosed group health amendment for your Department's review and approval. We are requesting to use this amendment in conjunction with our approved 2001 Insurance product series. This amendment is being filed to incorporate new Federal legislation and other business/product modifications. Our intent is to use this amendment for large and small employer groups. Similar forms are part of a nationwide filing. Because the enclosed form has been modified to reflect the laws and regulations of North Carolina, it will not be filed with Connecticut, our State of Domicile.

Our intent is to use this form to convey deletion of, addition of, or change in the specifics of a provision previously filed with your Department.

Explanation Variable Text

Included in this amendment are the following features:

- **Non-variable Text** that always appears in an issued document.
- **Variable Text** that may or may not appear in an issued document depending on the specific product and plan design selected by the Enrolling Group. Variable text is enclosed in [brackets]. Whenever text is bracketed, we have included text that explains the logic of the variable; brackets do not appear in the document issued to a member.
- **Instruction text** provides the logic for when text is included or removed. Please note that instruction text appears only in the filing copy and will not appear in the document issued to a member. Following are two examples of instruction text:

Include when group purchases benefits for obesity surgery.

Include when notification is required for hospice care.

Information contained within this form may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online viewing or issuance. We want to assure the Department that education will be provided to the brokers, employer groups and the employees regarding access and alternatives to electronic issuance.

Please note that this form is submitted to be used as a stand alone amendment for all existing business. We would also like to reserve the right to build the amendatory language into the approved forms or leave it in the amendment format, whichever we deem most appropriate.

Sincerely,

A handwritten signature in cursive script that reads "Tiffany Sievers".

Tiffany Sievers
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