

SERFF Tracking Number: UHLC-126432393 State: Arkansas
 Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 44401
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: 2009 Federal Form Filing
 Project Name/Number: /

Filing at a Glance

Company: UnitedHealthcare of Arkansas, Inc.
 Product Name: 2009 Federal Form Filing SERFF Tr Num: UHLC-126432393 State: Arkansas
 TOI: H21 Health - Other SERFF Status: Closed-Approved- State Tr Num: 44401
 Closed
 Sub-TOI: H21.000 Health - Other Co Tr Num: State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor
 Author: Ebony Terry Disposition Date: 12/29/2009
 Date Submitted: 12/26/2009 Disposition Status: Approved-Closed
 Implementation Date Requested: On Approval Implementation Date:
 State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Authorized
 Project Number: Date Approved in Domicile:
 Requested Filing Mode: Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Group
 Submission Type: Group Market Size: Small and Large
 Overall Rate Impact: Group Market Type:
 Filing Status Changed: 12/29/2009 Explanation for Other Group Market Type:
 State Status Changed: 12/29/2009
 Deemer Date: Created By: Ebony Terry
 Submitted By: Ebony Terry Corresponding Filing Tracking Number:
 Filing Description:
 2009 Federal Forms Schedule of Benefits Choice Revision

Company and Contact

Filing Contact Information

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 Rockville, MD 20850 301-838-5676 [FAX]

Filing Company Information

<i>SERFF Tracking Number:</i>	<i>UHLC-126432393</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>UnitedHealthcare of Arkansas, Inc.</i>	<i>State Tracking Number:</i>	<i>44401</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
<i>Product Name:</i>	<i>2009 Federal Form Filing</i>		
<i>Project Name/Number:</i>	<i>/</i>		
UnitedHealthcare of Arkansas, Inc.	CoCode: 95446	State of Domicile: Arkansas	
Plaza West Building	Group Code:	Company Type: HMO	
415 North McKinley Street, Suite 300	Group Name:	State ID Number:	
Little Rock, AK 72205	FEIN Number: 63-1036819		
(952) 992-7428 ext. [Phone]			

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare of Arkansas, Inc.	\$50.00	12/26/2009	33113486

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/29/2009	12/29/2009

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Disposition

Disposition Date: 12/29/2009

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	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Schedule of Benefits Choice	Approved-Closed	Yes

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Form Schedule

Lead Form Number: SBN.CHC.H.09.AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/29/2009	SBN.CHC.H.09.AR	Schedule Pages	Schedule of Benefits Choice	Revised	Replaced Form #: SBN.CHC.H.09.AR Previous Filing #: SBN.CHC.H.09.AR		X09H_SBN_ CHC 9.25.09 12.21.09.pdf

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.

¹Include if the plan design provides Designated Network Benefits in any benefit category.

²Include if the plan design requires a per occurrence deductible.

³Include when the plan design requires an annual maximum benefit. Include "," when the annual maximum benefit is included. Include "and" when the annual maximum benefit is not included.

¹**Designated Network Benefits** apply to Covered Health Services that are provided by a Network Physician or other provider that we have identified as a Designated Facility or Physician. Designated Network Benefits are available only for specific Covered Health Services as identified in the *Schedule of Benefits* table below. When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible, [²Per Occurrence Deductible,] Out-of-Pocket Maximum [³,] [³and] Maximum Policy Benefit [³and Annual Maximum Benefit] requirements as all other Covered Health Services provided by Network providers.]

Include when Enhanced Benefits program is sold.

[You may have an opportunity to elect to receive Covered Health Services from certain Network providers that we've identified as Designated Physicians or Designated Facilities. When you choose to seek care from certain Designated providers, the level of Benefits available to you is enhanced. You can determine the specific situations for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

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.

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

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

Include when Benefit Activation program involving reduction in Benefits is sold.

[Benefit Activation Program]

[For certain Covered Health Services you may be required to notify us to activate the highest level of Benefits. If you fail to notify us, your Benefits will be paid at [50 - 95]% of Eligible Expenses. Benefits for which activation is required are identified in the *Schedule of Benefits* table below.]

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.
- Clinical trials.

Include when group purchases benefits for congenital heart disease surgery that includes a designated network benefit level.

- [Congenital heart disease surgery.]

Include when group purchases benefits for accident-related dental services.

- [Dental services - accidental.]
- Dental services - anesthesia and hospitalization.

Include when group purchases benefits for infertility services.

- [Infertility services.]
- In vitro fertilization services.

Include when group purchases benefits for musculoskeletal disorders.

- [Musculoskeletal disorders of the face, neck or head.]

Include when group purchases benefits for obesity surgery.

- [Obesity surgery.]

¹*Include if notification applies only to orthotics that exceed a specific dollar amount and insert appropriate dollar amount*

- Orthotics devices [1over \$[1,000 - 5,000]].

¹*Include if notification applies only to prosthetics that exceed a specific dollar amount and insert appropriate dollar amount*

- [Prosthetic devices [1over \$[1,000 - 5,000]].]
- Transplants.

Include paragraphs below if pre-service benefit notification includes determining alternate levels of benefits.

¹*Include if Mental Health Benefits are sold.*

²*Include if Mental Health Benefits are not sold.*

[As we determine, if one or more alternative health services that meets the definition of a Covered Health Service in the *Certificate* under *Section 9: Defined Terms* are clinically appropriate and equally effective for prevention, diagnosis or treatment of a Sickness, Injury, [1Mental Illness,] [2mental illness,] substance use disorder 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] 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.

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. 2Include when SUD benefits are sold. 3Include when both MH and SUD benefits are sold.-1AInclude when benefits for Neurobiological Disorders - Autism Spectrum Disorders are sold.

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

[[1Mental Health Services [1-A(including psychiatric services for Autism Spectrum Disorders)]] [3and] [2Substance Use Disorder Services] are not subject to the pre-service notification requirements described above. Instead, 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 in the *Schedule of Benefits* table 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.

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.]

Care CoordinationSM

When we are notified as required, we will work with you to implement the Care CoordinationSM 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.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the pre-service notification requirements do not apply to you. Since Medicare is the primary

payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to notify us before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.

Include only when an Annual Maximum Benefit applies.

[The Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

Include here and in the table header only when a Designated Network Benefit applies for any benefit category.

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

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

Payment Term And Description	Amounts
Annual Deductible	
<p>¹<i>Include when an Outpatient Prescription Drug Rider is sold and the Annual Deductible applies to any combination of medical and RX benefits.</i></p> <p>²<i>Include when an Outpatient Prescription Drug Rider with separate Copayments for preventive medications is sold and the Annual Deductible does not apply to preventive medications.</i></p> <p>³<i>Include when an Outpatient Prescription Drug Rider is sold and when the Annual Deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the Annual Deductible.</i></p> <p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. [¹The Annual Deductible applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>. [²Benefits for Outpatient Prescription Drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [³Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the <i>Outpatient Prescription Drug Rider</i> are not subject to payment of the Annual Deductible.]</p> <p><i>Include when day/visit limits are reduced by the number of days/visit used toward meeting the deductible.</i></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><i>Include when dollar limits are reduced by the amount used</i></p>	<p><i>Include when separate individual and family deductibles apply (non-embedded).</i></p> <p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p><i>Include when individual deductible applies (embedded).</i></p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p><i>Include when individual (with family maximum) deductible applies (embedded).</i></p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</p> <p><i>Include when there is no annual deductible.</i></p> <p>[No Annual Deductible.]</p>

<p><i>toward meeting the deductible.</i></p> <p>[Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a dollar limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the amount used toward meeting the Annual Deductible.]</p> <p><i>Include when the carry-over provision applies.</i></p> <p>[Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.]</p> <p><i>Include paragraph if the roll-over provision applies to a group in any circumstance.</i></p> <p>[When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.]</p> <p><i>Include paragraph if the roll-over provision applies to a group changing from a calendar year to Policy year plan. ¹Include when this applies only to the individual deductible.</i></p> <p>[When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [¹This roll-over feature applies only to the individual 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 <i>Schedule of Benefits</i> table.</p> <p><i>Include only when a per occurrence deductible applies.</i></p> <p>[The Annual Deductible does not include any applicable Per Occurrence Deductible.]</p>	
<p><i>Include only when a per occurrence deductible applies.</i></p> <p>[Per Occurrence Deductible]</p>	
<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>	<p><i>Include when a per occurrence deductible applies to CHD surgery benefits.</i></p> <p>[CHD surgery - Inpatient Stay: [\$100 - 1,000] per day.]</p> <p>[CHD surgery - Inpatient Stay: [\$100 -</p>

<ul style="list-style-type: none"> The applicable Per Occurrence Deductible. The Eligible Expense.] 	<p>2,000] per Inpatient Stay.]</p> <p><i>Include when a per occurrence deductible applies to inpatient hospital benefits.</i></p> <p>[Hospital - Inpatient Stay: [\$100 - 1,000] per day.]</p> <p>[Hospital - Inpatient Stay: [\$100 - 2,000] per Inpatient Stay.]</p> <p><i>Include when a per occurrence deductible applies to outpatient surgery benefits.</i></p> <p>[Surgery - Outpatient: [\$10 - 1,000] per date of service.]</p> <p><i>Include when a per occurrence deductible applies to inpatient transplant benefits.</i></p> <p>[Transplant - Inpatient Stay: [\$100 - 1,000] per day.]</p> <p>[Transplant - Inpatient Stay: [\$100 - 2,000] per Inpatient Stay.]</p>
<p>Out-of-Pocket Maximum</p>	

<p>¹Include when OOPM includes the Annual Deductible.</p> <p>²Include when OOPM includes the Per Occurrence Deductible.</p> <p>³Include when OOPM includes Copayments.</p> <p>⁴Include when an Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.</p> <p>The maximum you pay per year for [¹the Annual Deductible,] [²the Per Occurrence Deductible,] [³Copayments] [¹⁻²⁻³or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [⁴The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this Schedule of Benefits, including Covered Health Services provided under the Outpatient Prescription Drug Rider.]</p> <p>⁵Include only when the plan design does not apply all Copayments/Coinsurance to the OOPM.</p> <p>[⁵Copayments and Coinsurance for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the Schedule of Benefits table.</p> <p>The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> Any charges for non-Covered Health Services. <p>Include bullet if notification requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.</p> <ul style="list-style-type: none"> [The amount Benefits are reduced if you do not notify us as required.] Charges that exceed Eligible Expenses. Copayments or Coinsurance for any Covered Health Service identified in the Schedule of Benefits table that does not apply to the Out-of-Pocket Maximum. <p>Include bullet when an Outpatient Prescription Drug Rider is sold and Copayments/Coinsurance do not apply to the overall OOPM.</p> <ul style="list-style-type: none"> [Copayments or Coinsurance for Covered Health Services provided under the Outpatient Prescription Drug Rider.] 	<p>Include when separate individual and family maximums apply (non-embedded).</p> <p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>Include when individual OOPM applies (embedded).</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>Include when individual (with family maximum) applies (embedded).</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>Include when the OOPM includes the Annual Deductible.</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>Include when the OOPM does not include the Annual Deductible.</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>Include when the OOPM includes the Per Occurrence Deductible.</p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p>Include when the OOPM does not include the Per Occurrence Deductible.</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p> <p>Include when there is no OOPM.</p> <p>[No Out-of-Pocket Maximum.]</p>
<p>Maximum Policy Benefit</p>	

<p>The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Policy.</p>	<p>[\$[1,000,000 - 10,000,000] per Covered Person.]</p> <p>[No Maximum Policy Benefit.]</p>
<p><i>Include only when an annual maximum benefit applies.</i></p> <p>[Annual Maximum Benefit]</p>	
<p>[The maximum amount we will pay for Benefits during the year.]</p>	<p>[\$[2,000 - 500,000] per Covered Person.]</p>
<p>Copayment</p>	
<p>Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.</p> <p>Please note that for Covered Health Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> • The applicable Copayment. • The Eligible Expense. <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	
<p>Coinsurance</p>	
<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

Include when benefit plan design has no additional 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.]

Include when benefit plan design has limits for either orthopedic or spine surgery.

[In addition to the limits stated below within the Covered Health Service categories in the *Schedule of Benefits* table, the following limits apply:]

Include when orthopedic surgery is limited.

¹*Include when orthopedic surgery is limited to a dollar amount per surgery.*

²*Include when orthopedic surgery is limited to a specific number of surgeries per lifetime.*

³*Include when orthopedic surgery is limited to both a dollar amount per surgery and a specific number of surgeries per lifetime.*

- [Benefits for Covered Health Services for orthopedic surgery for joint replacement are limited to [¹a maximum of \$[5,000 - 50,000] per surgery] [²[1 - 4] orthopedic [surgery] [surgeries] during the entire period of time a Covered Person is enrolled under the Policy] [³a maximum of \$[5,000 - 50,000] per surgery, not to exceed [1 - 4] orthopedic [surgery] [surgeries] during the entire period of time a Covered Person is enrolled under the Policy].]

Include when spine surgery is limited.

¹*Include when spine surgery is limited to a dollar amount per surgery.*

²*Include when spine surgery is limited to a specific number of surgeries per lifetime.*

³*Include when spine surgery is limited to both a dollar amount per surgery and a specific number of surgeries per lifetime.*

- [Benefits for non-emergent spine surgery, including all related services and devices, are limited to [¹a maximum of \$[5,000 - 75,000] per surgery] [²[1 - 4] spine [surgery] [surgeries] during the entire period of time a Covered Person is enrolled under the Policy] [³a maximum of \$[5,000 - 75,000] per surgery, not to exceed [1 - 4] spine [surgery] [surgeries] during the entire period of time a Covered Person is enrolled under the Policy].]

This limit does not apply to:

- ◆ Non-emergent surgeries for scoliosis or congenital defects.
- ◆ Emergent surgeries for traumatic spine/spinal cord injury, spinal cord tumor, cauda equine syndrome, infection or neurological motor deficit.]

Include when benefits for spine surgery are provided only after conservative treatment is received.

- [Benefits for non-emergent spine surgery are available only after a Covered Person receives a minimum of a six-week course of conservative, non-surgical treatment provided under the supervision of a Physician. Benefits for spine surgery related to traumatic spine/spinal cord Injury, spinal cord tumor, cauda equine syndrome, infection, neurological motor deficit, scoliosis and congenital defects are not subject to this prior conservative, non-surgical treatment requirement.]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Include for groups that purchase benefits for acupuncture services.</i></p> <p>1. [Acupuncture Services]</p>			
<p><i>Include the limit selected by the group.</i></p> <p>[Limited to [10 - 100] visits per year.]</p> <p>[Limited to [10 - 100] visits per year, not to exceed \$[100 - 5,000] in Eligible Expenses per year.]</p> <p>[Limited to \$[100 - \$5,000] in Eligible Expenses per year.]</p>	<p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>
<p>[2.] Ambulance Services</p>	<p>Pre-service Notification Requirement</p> <p>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.</p>		
<p>Emergency Ambulance</p> <p><i>Include the limit selected by the group.</i></p> <p>[Ground ambulance limited to \$[500 - 5,000] per year.]</p> <p><i>Include the limit selected by the group.</i></p> <p>[Air ambulance limited to \$[1,000 - 10,000] per year.]</p>	<p><i>Ground Ambulance:</i></p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[25 - 300] per transport]</p> <p>[100% after you pay a Copayment of \$[300 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[300 - 1,000] per day, up to a per day maximum of \$[300 - 1,000]]</p> <p><i>Air Ambulance:</i></p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[25 -</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Non-Emergency Ambulance</p> <p>Ground or air ambulance, as we determine appropriate.</p>	<p>2,500] per transport]</p> <p>[100% after you pay a Copayment of \$[2,500 - 10,000] per day]</p> <p>[100% after you pay a Copayment of \$[2,500 - 10,000] per day, up to a per day maximum of \$[2,500 - 10,000]]</p> <p><i>Ground Ambulance:</i></p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[25 - 300] per transport]</p> <p>[100% after you pay a Copayment of \$[300 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[300 - 1,000] per day, up to a per day maximum of \$[300 - 1,000]]</p> <p><i>Air Ambulance:</i></p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[25 - 2,500] per transport]</p> <p>[100% after you pay a Copayment of \$[2,500 - 10,000] per day]</p> <p>[100% after you pay a Copayment of \$[2,500 - 10,000] per day, up to a per day maximum of \$[2,500 - 10,000]]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>
<p><i>Include for groups that purchase benefits for clinical trials.</i></p> <p>[3.] [Clinical Trials]</p>			

<i>[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]</i>			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<i>When Clinical Trials benefit is included, pre-service notification requirement will always apply.</i>			
[Pre-service Notification Requirement]			
[You must notify us as soon as the possibility of participation in a clinical trial arises. If you don't notify us, you will be responsible for paying all charges and no Benefits will be paid.]			
[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> . Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)]	[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> .]		
<i>Include for groups that purchase benefits for congenital heart disease services.</i>			
[4.] [Congenital Heart Disease Surgeries]			
<i>Include if pre-service notification is required.</i>			
[Pre-service Notification Requirement]			
[For Designated Network Benefits you must notify us as soon as the possibility of a Congenital Heart Disease (CHD) surgery arises. If you do not notify us and if, as a result, the CHD services are not performed at a Designated Network Facility, Designated Network Benefits will not be paid.]			
¹ <i>Include both headings and this row when Designated Network Benefits are available.</i> <i>Include paragraph below when Designated Network Benefits are available.</i>	¹ Designated Network [[50 - 100]%] [100% after you pay a Copayment of \$[100 - 1,000] per day] [100% after you pay a Copayment of \$[100 - 2,000] per Inpatient]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
[When performed at a Designated Facility as part of the evaluation and treatment of CHD, Covered Health Services include diagnostic services,			

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>cardiac catheterization and all non-surgical management of CHD.]</p> <p><i>Include when CHD benefits are sold and when Network Benefits are available.</i></p> <p>[Network 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>]</p> <p><i>Include when use of a Designated Facility is required.</i></p> <p>[CHD surgeries must be received at a Designated Facility.]</p> <p><i>Include when Benefits are limited and insert the limit selected by the group.</i></p> <p>[Benefits for CHD surgeries that are not received at a Designated Facility are limited to \$[30,000 - 250,000] per CHD surgery.]</p>	<p>Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p>[¹ Network]</p> <p>[[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible is satisfied]</p>

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Include for groups that purchase benefits for accident-related dental services.</i></p> <p>[5.] [Dental Services - Accident Only]</p>			
<p><i>Include when pre-service notification is required.</i></p> <p><i>¹Include applicable reduction in Benefits or no Benefits.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[You must notify us five business days before follow-up (post-Emergency) treatment begins. (You do not have to notify us before the initial Emergency treatment.) If you fail to notify us as required, [¹Benefits will be reduced to [50 - 95]% of Eligible Expenses] [¹you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>[Limited to \$[2,000 - 5,000] per year. Benefits are further limited to a maximum of \$[500 - 1,500] per tooth.]</p>	<p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<p>[6.] Diabetes Services</p>			
<p>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</p> <p>Diabetes Self-Management Items</p> <p>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> <p><i>Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.</i></p> <p>[Benefits for insulin pumps are limited to \$[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[two-five] years].]</p>	<p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>¹Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.</i></p> <p>[¹Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>²Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold.</i></p> <p><i>³Include when sold with a plan that has an annual deductible and select either "are" or "are not."</i></p> <p><i>⁴Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."</i></p> <p>[²For diabetes equipment, Benefits will be the same as those stated under <i>Durable Medical Equipment</i>.</p> <p>For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [³and Benefits [are] [are not] subject to payment of</p>		

<i>[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]</i>			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>the Annual Deductible]. ⁴Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p>⁵Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold.</p> <p>⁶Include when sold with a plan that has an annual deductible and select either "are" or "are not."</p> <p>⁷Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."</p> <p>⁵For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [⁶and Benefits [are] [are not] subject to payment of the Annual Deductible]. [⁷Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]</p> <p>Benefits for diabetes supplies will be the same as those stated in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p>⁸Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold.</p> <p>⁹Include when sold with a plan that has an annual deductible and select either "are" or "are not."</p> <p>¹⁰Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."</p> <p>⁸For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [⁹and Benefits [are] [are not] subject to payment of the Annual Deductible]. [¹⁰Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p>		
<i>Include for groups that purchase benefits for DME.</i>			
[7.] [Durable Medical Equipment]			
<p><i>Include the limit selected by the group.</i></p> <p>¹Include either option as standard plan design.</p> <p>[¹Limited to \$[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].]</p> <p>[¹Limited per year as follows:</p> <ul style="list-style-type: none"> • [500 - 10,000] in Eligible Expenses for Tier 1.Tier 1 	[[50 - 100]%]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>includes disposable supplies necessary for the effective use of covered Durable Medical Equipment.]</p> <ul style="list-style-type: none"> • [\$[10,001 - 25,000] in Eligible Expenses for Tier 2.] • [\$[25,001 - 100,000] in Eligible Expenses for Tier 3.] <p>These Tier limits include repair. Benefits for replacement are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].]</p> <p><i>¹Include when Benefits are provided for speech aid and tracheo-esophageal voice devices.</i></p> <p><i>²Include when devices are not included in the annual DME limit.</i></p> <p>[¹Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every three years. Speech aid and tracheo-esophageal voice devices are [²not] included in the annual limits stated above.]</p> <p><i>Always include when the DME benefit is sold.</i></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>			
[8.] Emergency Health Services - Outpatient			

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Include when benefit is limited.</i></p> <p>[Limited to \$[100 - 5,000] per year.]</p> <p>Note: 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> <p><i>Include when covered health services performed at an emergency room are subject to the Copayments/Coinsurance stated under other benefit categories, in addition to the outpatient emergency Copayment stated in this section. (This will not apply when the emergency benefit is subject to Coinsurance only.)</i></p> <p>[In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed as an Emergency Health Service:</p> <ul style="list-style-type: none"> [Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient.</i>] [Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.</i>] [Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures -</i> 	<p>[[50 - 100] %]</p> <p><i>Include bracketed provision and select either #1 or #2 if the Copayment is waived.</i></p> <p>¹<i>Include as standard;</i> ²<i>Include only to match prior benefit plans.</i></p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit. [If you are admitted as an inpatient to a Network Hospital [¹directly from the Emergency room] [²within 24 hours of receiving outpatient Emergency treatment for the same condition], you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.]]</p> <p>[100% for the first [#] visits in a year; [50 - 90] % for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; [50 - 90] % for any subsequent visits in that year]</p> <p><i>Include for 2-tiered Copayment option.</i></p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit <i>(The Amount We Pay, based on Eligible Expenses)</i>	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Outpatient Diagnostic and Therapeutic.]</i></p> <ul style="list-style-type: none"> <i>[Outpatient surgery procedures described under Surgery - Outpatient.]</i> <i>[Outpatient therapeutic procedures described under Therapeutic Treatments - Outpatient.]</i> <p>¹<i>Include bracketed reference to Manipulative treatment when Manipulative treatment benefits are sold.</i></p> <ul style="list-style-type: none"> <i>[Rehabilitation therapy procedures described under Rehabilitation Services - Outpatient Therapy [¹and Manipulative Treatment].]</i> 	<p>first [#] visits in a year; 100% after you pay a Copayment of \$[50 - 650] for any subsequent visits in that year]</p> <p><i>Include for 3-tiered Copayment option.</i></p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; 100% after you pay a Copayment of \$[50 - 650] per visit for the next [#] visits in a year; 100% after you pay a Copayment of \$[100 - 700] for any subsequent visits in that year]</p> <p><i>Include for 4-tiered Copayment option.</i></p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; 100% after you pay a Copayment of \$[50 - 650] per visit for the next [#] visits in a year; 100% after you pay a Copayment of \$[100 - 500] for the next [#] visits in a year; 100% after you pay a Copayment of \$[150 - 700] for any subsequent visits in that year]</p> <p><i>Include if plan design includes retrospective review of emergency services.</i></p>		

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[100% after you pay a Copayment of \$[5 - 500] per visit for a condition defined as an Emergency; 100% after you pay a Copayment of \$[50 - 650] per visit for a condition that does not meet the definition of an Emergency]		
<p><i>Include as standard for groups of 2 to 15 and 15+.</i></p> <p>[9.] Hearing Aids</p>			
<p><i>Include the limit selected by the group.</i></p> <p><i>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.</i></p> <p>[Limited to \$[2,800 - 5,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[three-five] years].]</p> <p>No Copayment, Coinsurance or Deductible will be applicable to Hearing Aid Coverage.</p>	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[10.] Home Health Care			
<p><i>Include the limit selected by the group.</i></p> <p>[Limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.]</p> <p>[Limited to \$[500 - 5,000] per year.]</p> <p>[Limited to [40 - 200] visits per year to a maximum of \$[500 - 5,000] in Eligible Expenses per year.]</p> <p><i>Include when infusion administration only is not included in the limit.</i></p> <p>[This visit limit does not include any</p>	[[50 - 100]%]	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
service which is billed only for the administration of intravenous infusion.]			
[11.] Hospice Care			
	[[50 - 100]%) [100% after you pay a Copayment of \$[5 - 100] per day]	[Yes] [No]	[Yes] [No]
[12.] Hospital - Inpatient Stay			
<p><i>Include when Benefit Activation Program is sold.</i></p> <p>¹<i>Include applicable Benefit level.</i></p> <p style="text-align: center;">[Benefit Activation Notification Requirement]</p> <p>[For certain Covered Health Services [or as a result of certain diagnoses] you are required to notify us to activate the highest level of Benefits. If you fail to notify us, your Benefits will be paid at [150 - 95]% of Eligible Expenses. You can determine the specific services [or diagnoses] for which notification is required by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>			
<p>¹<i>Include both headings and this row when Designated Network Benefits apply.</i></p> <p><i>Include when enhanced benefits apply to specific inpatient services.</i></p> <p>²<i>Include when Physician's fees are paid under the facility charge.</i></p> <p>[When you choose to seek care from Designated Network facilities for certain surgical procedures [or as a result of certain diagnoses], your Benefits will be enhanced as described below:]</p> <ul style="list-style-type: none"> • [The Copayment you pay for the facility charge [²and Physician's fees] for services provided at a Designated Network facility will be reduced to [\$0 - 1,000]. [The maximum reduction in Copayments is \$[10 - 1,000].]] • [The Coinsurance you pay for the facility charge [²and Physician's fees] for services 	<p>¹Designated Network]</p> <p>[[50 - 100]%)</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 10,000] per Inpatient Stay]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible is satisfied]</p>

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>provided at a Designated Network facility will be reduced to [0 - 50]% or \$[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of \$[10 - 1,000].</p> <p>[You can determine the specific surgical procedures or diagnoses for which enhanced Benefits are available by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>	<p><i>[¹ Network]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 10,000] per Inpatient Stay]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible is satisfied]</p>
<p><i>Include for groups that purchase infertility benefits.</i></p> <p>[13]. [Infertility Services]</p>			
<p><i>When this benefit is purchased, pre-service notification will always be required. ¹Include applicable reduction in Benefits or no Benefits.</i></p> <p align="center">[Pre-service Notification Requirement]</p> <p>[You must notify us as soon as the possibility of the need for Infertility Services arises. If you fail to notify us as required, [¹Benefits will be reduced to [50 - 95]% of Eligible Expenses] [¹you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p><i>¹Include both headings and this row when Designated Network Benefits apply.</i></p>	<p><i>[¹ Designated Network]</i></p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Include the limit selected by the group.</i></p> <p>¹<i>Include when the maximum benefit is combined with infertility drugs under the RX rider.</i></p> <p>[Limited to \$[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [¹This limit includes Benefits for infertility medications provided under the <i>Outpatient Prescription Drug Rider.</i>] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under <i>Physician's Office Services - Sickness and Injury</i> below.]</p>	<p>[[50 - 100] %]</p> <p>[¹ Network]</p> <p>[[50 - 100] %]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<p>[14.] Lab, X-Ray and Diagnostics - Outpatient</p>			
<p>¹<i>Include both headings and this row when Designated Network Benefits apply.</i></p> <p><i>Include limit selected by group.</i></p> <p>[Limited to \$[100 - 5,000] per year.]</p>	<p>[¹ Designated Network]</p> <p>[[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[¹ Network]</p> <p>[[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>
<p>[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</p>			
<p>¹<i>Include both headings and this row when Designated Network Benefits apply.</i></p> <p><i>Include limit selected by group.</i></p> <p>[Limited to \$[100 - 5,000] per year.]</p>	<p>[¹ Designated Network]</p> <p>[[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[25 -</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

<i>[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]</i>			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	500] per service] [¹ Network] [[50 - 100]%) [100% after you pay a Copayment of \$[25 - 500] per service]	[Yes] [No]	[Yes] [No]
<i>Include for groups that purchase mental health benefits. [Include as standard for groups of 2 to 15]</i> [16.] Mental Health Services			
<i>When this benefit is purchased, prior authorization will always be required.</i> ¹ Include as standard when parity applies. ² Include applicable reduction in Benefits. ³ Include as standard when parity does not apply.			
[Prior Authorization Requirement] [You must obtain prior authorization through the Mental Health/Substance Use Disorder Designee in order to receive Benefits. Without authorization, [¹ Benefits will be reduced to [² 50 - 95]%) of Eligible Expenses] [³ you will be responsible for paying all charges and no Benefits will be paid].]			
Note: <i>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. 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 "Depending upon" provisions further below."</i>	<i>[Inpatient/Intermediate]</i> [[50 - 100]%) [100% after you pay a Copayment of \$[100 - 1,000] per day] [100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No]
<i>Select from these limit options when limits apply only to Mental Health Services described in this section.</i> [Inpatient/Intermediate Mental Health	<i>[Outpatient]</i> [[50 - 100]%) [100% after you pay a	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Services are limited to [10 - 100] days per year.]</p> <p>[Outpatient <i>Mental Health Services</i> are limited to [10 - 100] visits per year.]</p> <p><i>Select from these limit options when limits apply to Mental Health Services described in this section combined with Neurobiological Disorders - Autism Spectrum Disorders below.</i></p> <p>[Benefits for any combination of <i>Mental Health Services</i> described in this section and <i>Neurobiological Disorders - Autism Spectrum Disorders</i> described below are limited as follows:</p> <ul style="list-style-type: none"> • [10 - 100] days per year for Inpatient/Intermediate <i>Mental Health Services</i> and <i>Neurobiological Disorders - Autism Spectrum Disorders</i>. • [10 - 100] visits per year for outpatient <i>Mental Health Services</i> and <i>Neurobiological Disorders - Autism Spectrum Disorders</i>.] <p><i>Select from these limit options when limits apply to Mental Health Services described in this section combined with Substance Use Disorder Services below.</i></p> <p>[Benefits for any combination of <i>Mental Health Services</i> described in this section and <i>Substance Use Disorder Services</i> described below are limited as follows:</p> <ul style="list-style-type: none"> • [10 - 100] days per year for Inpatient/Intermediate <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. • [10 - 100] visits per year for outpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] 	<p>Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>		

<i>[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]</i>			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Note: 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.</i></p>	<p>[Depending upon where the Covered Health Service is provided, Benefits for outpatient <i>Mental Health Services</i> will be the same as those stated under <i>Physician's Office Services - Sickness and Injury</i>, and Benefits for inpatient/intermediate <i>Mental Health Services</i> will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>.]</p> <p><i>Include when outpatient visits for medication management are paid at 100%.</i></p> <p>[Benefits for outpatient visits for medication management will be paid at 100%.]</p>		
<p><i>Include for groups that purchase mental health benefits.</i></p> <p>[17.] [Neurobiological Disorders - Autism Spectrum Disorder Services]</p>			
<p><i>When this benefit is purchased, prior authorization will always be required.</i></p> <p>¹<i>Include as standard when parity applies.</i></p> <p>²<i>Include applicable reduction in Benefits.</i></p> <p>³<i>Include as standard when parity does not apply.</i></p> <p style="text-align: center;">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization through the Mental Health/Substance Use Disorder Designee in order to receive Benefits. Without authorization, [¹Benefits will be reduced to [²50 - 95%] of Eligible Expenses] [³you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>Note: <i>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.</i></p> <p><i>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 "Depending upon" provisions further below."</i></p>	<p><i>[Inpatient/Intermediate]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Select from these limit options when limits apply only to Neurobiological Disorders - Autism Spectrum Disorders described in this section.</i></p> <p><i>[Inpatient/Intermediate Neurobiological Disorders -Autism Spectrum Disorders are limited to [10 - 100] days per year.]</i></p> <p><i>[Outpatient Neurobiological Disorders - Autism Spectrum Disorders are limited to [10 - 100] visits per year.]</i></p> <p><i>Select from these limit options when limits apply to Neurobiological Disorders - Autism Spectrum Disorders described in this section combined with Mental Health Services above.</i></p> <p><i>[Benefits for any combination of Neurobiological Disorders - Autism Spectrum Disorders described in this section and Mental Health Services described above are limited as follows:</i></p> <ul style="list-style-type: none"> <i>• [10 - 100] days per year for Inpatient/Intermediate Neurobiological Disorders - Autism Spectrum Disorders and Mental Health Services.</i> <i>• [10 - 100] visits per year for outpatient Neurobiological Disorders - Autism Spectrum Disorders and Mental Health Services.]</i> <p>Note: <i>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.</i></p>	<p><i>[Outpatient]</i></p> <p><i>[[50 - 100]%]</i></p> <p><i>[100% after you pay a Copayment of \$[5 - 100] per visit]</i></p> <p><i>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</i></p> <p><i>[100% for visits for medication management]</i></p>	<p><i>[Yes] [No]</i></p>	<p><i>[Yes] [No]</i></p>
	<p><i>[Depending upon where the Covered Health Service is provided, Benefits for outpatient Neurobiological Services - Autism Spectrum Disorder Services will be the same as those stated under Physician's Office Services - Sickness and Injury, and Benefits for inpatient/intermediate Neurobiological Services - Autism Spectrum Disorder Services will be the same as those stated under Hospital - Inpatient Stay in this Schedule of Benefits.]</i></p> <p><i>Include when outpatient visits for medication management are paid at 100%.</i></p> <p><i>[Benefits for outpatient visits for medication management will be</i></p>		

<i>[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]</i>			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	paid at 100%.]		
<i>Include for groups that purchase benefits for obesity surgery.</i> [18.] [Obesity Surgery]			
<i>When this benefit is purchased, pre-service notification will always be required. ¹Include applicable Benefit level.</i>			
[Pre-service Notification Requirement]			
[You must notify us [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to notify us as required, Benefits will be reduced to [¹ 50 - 95]% of Eligible Expenses.]			
[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]			
¹ <i>Include headings and this row if Designated Network Benefits are available.</i> ² <i>Insert the limit selected by the group.</i> [Benefits are limited to \$[² 50,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]	[¹ Designated Network] [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>] [¹ Network] [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>]		
<i>Include if group purchases benefits for ostomy supplies.</i> [19.] [Ostomy Supplies]			
<i>Include the limit selected by the group.</i> [Limited to \$[500 - 25,000] per year.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[20.] Pharmaceutical Products - Outpatient			
¹ <i>Include headings and this row when Designated Network Benefits apply.</i> <i>Include limit selected by group.</i> [Limited to \$[100 - 5,000] per year.]	[¹ Designated Network] [[50 - 100]%] [100% after you pay a Copayment of \$[5 -	[Yes] [No] [Yes, except when provided during a	[Yes] [No] [Yes, except when provided during a Physician office

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>100] per Pharmaceutical Product]</p> <p><i>Include when Coinsurance is tiered and select the appropriate number of tiers by plan design.</i></p> <p>[[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]</p> <p>[¹ Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per Pharmaceutical Product]</p> <p><i>Include when Coinsurance is tiered and select the appropriate number of tiers by plan design.</i></p> <p>[[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]</p>	<p>Physician office visit]</p> <p>[Yes] [No]</p> <p>[Yes, except when provided during a Physician office visit]</p>	<p>visit]</p> <p>[Yes] [No]</p> <p>[Yes, except when provided during a Physician office visit]</p>

[21.] Physician Fees for Surgical and Medical Services

Include when Benefit Activation Program is sold.

¹*Include applicable Benefit level.*

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[Benefit Activation Notification Requirement]</p> <p>[For Covered Health Services [as a result of certain diagnoses or] from Physicians in the following specialties, you are required to notify us to activate the highest level of Benefits: [Cardiology,] [Cardiac/Cardio-thoracic Surgery,][Orthopedic Surgery,] [Neurosurgery,] [Allergy,] [Nephrology,] [Neurology,] [Oncology,] [Pulmonology,] [Rheumatology,] [Endocrinology,] [Infectious Disease,] [Gastroenterology,] [Obstetrics/Gynecology,] [Reproductive Endocrinology]. If you fail to notify us, your Benefits will be paid at [150 - 95]% of Eligible Expenses. You can determine the specialties [or diagnoses] for which notification is required by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>			
<p>¹<i>Include headings and this row when Designated Network Benefits apply.</i></p> <p><i>Include when enhanced benefits apply to specific Physician services.</i></p> <p>[When you choose to seek care [as a result of certain diagnoses or] from Designated Network Physicians as identified below, your Benefits will be enhanced as described:]</p> <p>[Specialties:]</p> <ul style="list-style-type: none"> • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] 	<p>[¹ Designated Network]</p> <p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

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"> [All specialties for which we provide designation.] <p>[Enhanced Benefits:]</p> <ul style="list-style-type: none"> [The Coinsurance you pay for Physician's Fees from a Designated Network Physician will be reduced to [0 - 50]% or \$[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of \$[10 - 1,000].] <p>[You can determine the specific services for which enhanced Benefits are available by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>	<p><i>[¹ Network]</i></p> <p>[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<p>[22.] Physician's Office Services - Sickness and Injury</p>			
<p><i>Include when Benefit Activation Program is sold.</i></p> <p><i>¹Include applicable Benefit level.</i></p> <p align="center">[Benefit Activation Notification Requirement]</p> <p>[For Covered Health Services [as a result of certain diagnoses or] from Physicians in the following specialties, you are required to notify us to activate the highest level of Benefits: [Cardiology,] [Cardiac/Cardio-thoracic Surgery,][Orthopedic Surgery,] [Neurosurgery,] [Allergy,] [Nephrology,] [Neurology,] [Oncology,] [Pulmonology,] [Rheumatology,] [Endocrinology,] [Infectious Disease,] [Gastroenterology,] [Obstetrics/Gynecology,] [Reproductive Endocrinology]. If you fail to notify us, your Benefits will be paid at [¹50 - 95]% of Eligible Expenses. You can determine the specialties [or diagnoses] for which notification is required by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>			
<p><i>Include if group chooses to limit benefit. ¹Insert limit selected by group</i></p> <p>[Limited to [¹2 - 10] visits per year.]</p> <p><i>¹Include headings and this row when Designated Network Benefits apply.</i></p> <p><i>Include when enhanced benefits apply to specific physician office services.</i></p>	<p><i>[¹ Designated Network]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[When you choose to seek care [as a result of certain diagnoses or] from Designated Network Physicians as identified below, your Benefits will be enhanced as described:]</p> <p>[Specialties:]</p> <ul style="list-style-type: none"> • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] <p>[Enhanced Benefits:]</p> <ul style="list-style-type: none"> • [The Copayment you pay for [the initial office visit] [[1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to \$[0 - 1,000]. [The maximum reduction in Copayments is \$[10 - 1,000].]] • [The Coinsurance you pay for [the initial office visit] [[1 - 100] office visit(s)] provided by a Designated Network Physician 	<p>Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p>		

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>will be reduced to [0 - 50]% or \$[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of \$[10 - 1,000].]</p> <p>[You can determine the specific specialties for which enhanced Benefits are available by going to [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.]</p> <p><i>Include when covered health services performed in a physician's office are subject to the Copayments/Coinsurance stated under other benefit categories, in addition to the office visit Copayment stated in this section. (This will not apply when the office visit benefit is subject to Coinsurance only.)</i></p> <p>[In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office:</p> <ul style="list-style-type: none"> • [Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient.</i>] • [Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.</i>] • [Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>] • [Outpatient surgery procedures described under <i>Surgery -</i> 	<p>[¹ Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 -</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Outpatient.</i>]</p> <ul style="list-style-type: none"> [Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i>] <p>¹Include bracketed reference to <i>Manipulative treatment when Manipulative treatment benefits are sold.</i></p> <ul style="list-style-type: none"> [Rehabilitation therapy procedures described under <i>Rehabilitation Services - Outpatient Therapy</i> [¹and <i>Manipulative Treatment</i>].] 	<p>100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p>		
<p>¹Always include <i>Maternity Services</i> benefit except when small groups (14 or fewer employees) choose to exclude. ²If <i>Maternity Services</i> are excluded, <i>Complications of Pregnancy</i> must always be included.</p> <p>[23.] Pregnancy - [¹Maternity Services] [²Complications of Pregnancy only]</p>			
<p>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.</p>			
	<p>¹Include when benefits are provided for maternity services.</p> <p>³Include when an annual deductible applies.</p> <p>⁴Include when services in the Physician's office are subject to a Copayment.</p> <p>[¹Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> [³except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [⁴For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]</p> <p>²Include when benefits are provided for complications of pregnancy only.</p>		

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
² Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>			
[24.] Preventive Care Services			
<p>Physician office services</p> <ul style="list-style-type: none"> Well baby and well child care includes, but not limited to, 20 visits at approximately the following age intervals: birth, two weeks, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, three years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years. <p>No Copayment, Coinsurance or Deductible will be applicable to children's immunizations.</p> <p>Lab, X-ray or other preventive tests:</p> <p>No deductible will be applicable to Prostate Cancer Screening.</p>	<p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p>
[25.] Prosthetic Devices and Services			
<p><i>Include if notification is required.</i></p> <p>¹Include when notification applies only to prosthetics that exceed a minimum dollar amount and insert applicable dollar amount.</p> <p>²Include applicable reduction in Benefits or no Benefits.</p>			
[Pre-service Notification Requirement]			
<p>[For Non-Network Benefits you must notify us before obtaining prosthetic devices ¹that exceed \$[1,000 - 5,000] in cost per device]. If you fail to notify us as required, ²Benefits will be reduced to [50 - 95]% of</p>			

<i>[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]</i>			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Eligible Expenses] [² you will be responsible for paying all charges and no Benefits will be paid.]			
Benefits for replacement are limited to a single purchase of each type of prosthetic device every three years.	[[50 - 100]%	[Yes] [No]	[Yes] [No]
[26.] Reconstructive Procedures			
	<p>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>.</p> <p><i>Include when group does not purchase benefits for prosthetic devices.</i></p> <p>¹<i>Include when sold with a plan that has an annual deductible and select either "are" or "are not."</i></p> <p>²<i>Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."</i></p> <p>[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [¹and Benefits [are] [are not] subject to payment of the Annual Deductible]. [²Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p>		
<p><i>Include entire section when rehabilitation services benefit is sold.</i></p> <p>¹<i>Include when Manipulative Treatment benefits are sold.</i></p> <p>[27.] [Rehabilitation Services - Outpatient Therapy [¹and Manipulative Treatment]]</p>			
<p><i>Include when per therapy limits apply.</i></p> <p>¹<i>Include when Manipulative Treatment benefits are sold.</i></p> <p>²<i>Include when vision therapy benefits are sold.</i></p> <p>[Limited per year as follows:</p> <ul style="list-style-type: none"> • [10-100] visits of physical therapy. • [10-100] visits of occupational therapy. • [¹[10-100] visits of Manipulative 	<p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Treatment.]</p> <ul style="list-style-type: none"> • [10-100] visits of speech therapy. • [10-100] visits of pulmonary rehabilitation therapy. • [10-100] visits of cardiac rehabilitation therapy. • [10-100] visits of post-cochlear implant aural therapy. • [²[10-100] visits of vision therapy.] <p><i>Include when combined therapy visit limits apply.</i></p> <p>¹<i>Include when Manipulative Treatment benefits are sold and included in the combined limit. If they are sold but not included in the combined limit, they should be stated in the above separate limits.</i></p> <p>²<i>Include when vision therapy benefits are sold.</i></p> <p>[Any combination of physical therapy, occupational therapy, [¹Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [²and vision therapy] is limited to [10 - 160] visits per year.]</p> <p><i>Include when combined therapy dollar limits apply.</i></p> <p>¹<i>Include when Manipulative Treatment benefits are sold and included in the combined limit. If they are sold but not included in the combined limit, they should be stated in the above separate limits.</i></p> <p>²<i>Include when vision therapy benefits are sold.</i></p> <p>[Any combination of physical therapy,</p>			

<i>[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]</i>			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
occupational therapy, [¹ Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [² and vision therapy] is limited to \$[750 - 12,000] per year.]			
[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
<i>¹Include headings and this row when Designated Network Benefits apply.</i>	<i>[¹ Designated Network]</i> [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	<i>[¹ Network]</i> [50 - 100]%	[Yes] [No]	[Yes] [No]
[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
<i>Include limit selected by group.</i> [Limited to [40 - 180] days per year.]	[[50 - 100]%] [100% after you pay a Copayment of \$[50 - 1,000] per day] <i>Copayment option below identified as #1 to be tied only to either of the options #1 below with an Inpatient Stay maximum.</i> [¹ 100% after you pay a Copayment of \$[50 - 2,000] per Inpatient Stay] [¹ 100% after you pay a Copayment of \$[50 - 1,000] per day to a maximum Copayment of \$[50 - 5,000] per Inpatient Stay] <i>Variable #1 can be used only with options</i>	[Yes] [No]	[Yes] [No]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p><i>numbered #1 above.</i></p> <p>[¹If you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility, any combination of Copayments required for the Inpatient Stay in a Hospital and the Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility will apply to the stated maximum Copayment per Inpatient Stay.]</p> <p>[No Copayment applies if you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility.]</p>		
<p><i>Include for groups that purchase substance use disorder benefits. [Include as standard for groups of 2 to 15]</i></p> <p>[30.] Substance Use Disorder Services</p>			
<p><i>When this benefit is purchased, prior authorization will always be required.</i></p> <p>¹<i>Include as standard when parity applies.</i></p> <p>²<i>Include applicable reduction in Benefits.</i></p> <p>³<i>Include as standard when parity does not apply.</i></p> <p align="center">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization through the Mental Health/Substance Use Disorder Designee in order to receive Benefits. Without authorization, [¹Benefits will be reduced to [²50 - 95]% of Eligible Expenses] [³you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>Note: <i>When the underlying medical plan does not apply visit or day limits,</i></p>	<p><i>[Inpatient/Intermediate]</i></p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>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.</i></p> <p><i>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 "Depending upon" provisions further below."</i></p>	<p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p>		
<p><i>Select from these limit options when limits apply only to Substance Use Disorder Services described in this section.</i></p> <p>[Inpatient/Intermediate Substance Use Disorder Services are limited to [10 - 100] days per year.]</p> <p>[Outpatient Substance Use Disorder Services are limited to [10 - 100] visits per year.]</p> <p><i>Select from these limit options when limits apply to Substance Use Disorder Services described in this section combined with Mental Health Services above.</i></p> <p>[Benefits for any combination of Substance Use Disorder Services described in this section and Mental Health Services described above are limited as follows:</p> <ul style="list-style-type: none"> • [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.] 	<p><i>[Outpatient]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Note: 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.</i></p>	<p>[Depending upon where the Covered Health Service is provided, Benefits for outpatient <i>Substance Use Disorder Services</i> will be the same as those stated under <i>Physician's Office Services - Sickness and Injury</i>, and Benefits for inpatient/intermediate <i>Substance Use Disorder Services</i> will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>.]</p> <p><i>Include when outpatient visits for medication management are paid at 100%.</i></p> <p>[Benefits for outpatient visits for medication management will be paid at 100%.]</p>		
<p>[31.] Surgery - Outpatient</p>			
<p><i>Include when Benefit Activation Program is sold.</i></p> <p>¹<i>Include applicable Benefit level.</i></p> <p style="text-align: center;">[Benefit Activation Notification Requirement]</p> <p>[For certain surgical procedures you are required to notify us to activate the highest level of Benefits. If you fail to notify us, your Benefits will be paid at [¹50 - 95]% of Eligible Expenses. You can determine the specific surgical procedures for which notification is required by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>			
<p>¹<i>Include headings and this row when Designated Network Benefits apply.</i></p> <p><i>Include provision below when enhanced benefits apply to specific outpatient surgical services.</i></p> <p>²<i>Include when Physician's fees are paid under the facility charge.</i></p> <p>[When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as follows:]</p> <ul style="list-style-type: none"> [The Copayment you pay for the facility charge [²and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [\$0 - 1,000]. [The maximum reduction in Copayments is \$[10 - 1,000].]] [The Coinsurance you pay for the facility charge [²and 	<p>[¹ Designated Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service]</p> <p>[100%after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year]]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible is satisfied]</p>

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [0 - 50]% or \$[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of \$[10 - 1,000].]</p> <p>[You can determine the specific surgical procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>	<p>[¹ Network]</p> <p>[[50 - 100]%]</p> <p>[[100% after you pay a Copayment of \$[10 - 1,000] per date of service]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year]]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible is satisfied]</p>
<p><i>Include when group purchases TMJ benefit.</i></p> <p>[32.] Temporomandibular Joint Services</p>			
<p><i>Include the limit selected by the group.</i></p> <p>[Limited to \$[1,000 - 20,000] per year.]</p>	<p>[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>]</p>		
<p>[33.] Therapeutic Treatments - Outpatient</p>			
<p>¹<i>Include headings and this row when Designated Network Benefits apply.</i></p>	<p>[¹ Designated Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[25 -</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	100] per treatment] <i>[¹ Network]</i> [[50 - 100]%] [100% after you pay a Copayment of \$[25 - 100] per treatment]	[Yes] [No]	[Yes] [No]
[34.] Transplantation Services			
Pre-service Notification Requirement 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.			
Transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility.	[[50 - 100]%] [100% after you pay a Copayment of \$[100 - 1,000] per day] [100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
[35.] Urgent Care Center Services			
<i>Include when urgent care services are limited and insert the limit selected by the group.</i> [Limited to \$[100 - 5,000] per year.] [Limited to [2 - 10] visits per year.] <i>Include when covered health services performed at an urgent care center are subject to the Copayments/Coinsurance stated under other benefit categories, in addition to the urgent care Copayment stated in this section. (This will not</i>	[[50 - 100]%] [100% after you pay a Copayment of \$[5 - 150] per visit] [100% after you pay a Copayment of \$[5 - 150] per visit to a maximum Copayment of \$[5 - 5,000] per year] [100% for the first [#] visits in a year; [50 -	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>apply when the urgent care benefit is subject to Coinsurance only.)</i></p> <p>[In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center:</p> <ul style="list-style-type: none"> • [Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient.</i>] • [Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.</i>] • [Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>] • [Outpatient surgery procedures described under <i>Surgery - Outpatient.</i>] • [Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i>] <p>¹<i>Include bracketed reference to Manipulative treatment when Manipulative treatment benefits are sold.</i></p> <ul style="list-style-type: none"> • [Rehabilitation therapy procedures described under <i>Rehabilitation Services - Outpatient Therapy</i> [¹and <i>Manipulative Treatment</i>.]] 	<p>90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p>		
<p><i>Include when group purchases benefits for vision exams.</i></p>			

<i>[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]</i>			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[36.] [Vision Examinations]			
[Limited to [1 exam] [[2-3] exams] per year.] [Limited to [1 exam] [[2-3] exams] every [2 - 3] years.]	[[50 - 100] %] [100% after you pay a Copayment of [\$5 - 75] per visit]	[Yes] [No]	[Yes] [No]
<i>Include when group purchases benefits for wigs.</i>			
[37.] [Wigs]			
<i>Include the limit selected by the group.</i> [Limited to \$[100 - 1,000] per year.] [Limited to \$[100 - 5,000] every [24 - 36] months.]	[[50 - 100] %]	[Yes] [No]	[Yes] [No]
Additional Benefits Required By Arkansas Law			
[38.] Dental Services - Anesthesia and Hospitalization			
Pre-service Notification Requirement			
Any applicable notification requirements will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i> .			
¹ <i>Include both headings and this row when Designated Network Benefits apply</i>	[¹ Designated Network] [Benefits will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i> .] [¹ Network] Benefits will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i> .		
[39.] In Vitro Fertilization Services			
¹ <i>Include applicable reduction in Benefits or no Benefits.</i>			
Pre-service Notification Requirement			
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, [¹ Benefits will be reduced to [50 - 95] % of Eligible Expenses] [¹ you will be responsible for paying all charges and no Benefits will be paid].			
¹ <i>Include both headings and this row when Designated Network Benefits</i>	[¹ Designated Network]		

[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>apply</i></p> <p>Limited to a lifetime maximum of \$15,000.</p>	<p>[[50 - 100] %]</p> <p>[¹ Network]</p> <p>[[50 - 100] %]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>
[40.] Medical Foods			
	<p><i>¹Include when group purchases the Outpatient Prescription Drug Rider.</i></p> <p>Depending upon where the Covered Health Service is provided, Benefits will be [50 - 100] % [¹or as provided under the Outpatient Prescription Drug Rider].</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<p><i>Mandated offer in Arkansas.</i></p> <p>[[41.] Musculoskeletal Disorders of the Face, Neck or Head]</p>			
<p align="center">[Pre-service Notification Requirement]</p> <p align="center">[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>			
<p><i>¹Include both headings and this row when Designated Network Benefits apply</i></p> <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>.]</p> <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>.]</p> <p><i>Include the limit selected by the group.</i></p> <p>[Limited to [10 - 100] visits per year.]</p>	<p>[¹ Designated Network]</p> <p>[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>.]</p> <p>[¹ Network]</p> <p>[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>.]</p> <p>[[50 - 100] %]</p> <p>[100% after you pay a</p>		
	<p>[[50 - 100] %]</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

<i>[When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]</i>			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Copayment of \$[5 - 75] per visit] [100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit]		
[42.] Orthotic Devices and Services			
<p><i>Include if notification is required.</i></p> <p><i>¹Include when notification applies only to orthotics that exceed a minimum dollar amount and insert applicable dollar amount.</i></p> <p><i>²Include applicable reduction in Benefits or no Benefits.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[For Non-Network Benefits you must notify us before obtaining orthotic devices [¹that exceed \$[1,000 - 5,000] in cost per device. If you fail to notify us as required, [²Benefits will be reduced to [50 - 95]% of Eligible Expenses] [²you will be responsible for paying all charges and no Benefits will be paid].]</p>			
Benefits for replacement are limited to a single purchase of each type of orthotic device every three years.	[Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]

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 *Certificate*.

Include paragraph below if pre-service benefit notification includes determining alternate levels of benefits.

¹Include when group purchases MH benefits. ²Include when group does not purchase MH benefits.

[If one or more alternative health services that meets the definition of Covered Health Service in the *Certificate* under *Section 9: Defined Terms* are clinically appropriate and equally effective for prevention, diagnosis or treatment of a Sickness, Injury, [¹Mental Illness,] [²mental illness,] substance use disorder 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:

¹Include if the plan design provides Designated Network Benefits in any benefit category.

- When Covered Health Services are received from a [¹Designated Network and] 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 or authorized by Arkansas law.

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] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

Continuity of Care

Continuity of care is provided under the Policy. In order for health services to be covered as Network Benefits, you must notify the company immediately if either of the following situations applies to you:

- Newly Eligible Persons who are being treated by a Non-Network provider for a current episode of an acute condition may continue to receive treatment from the Non-Network provider until the earlier of (1) the end of the current episode of treatment or (2) 90 days.
- Covered Persons who are being treated for a current episode of an acute condition by a Network provider when the provider's contract terminates may continue to receive treatment from that provider until the earlier of (1) the end of the current episode of treatment or (2) 90 days.

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

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.

SERFF Tracking Number: UHLC-126432393

State: Arkansas

Filing Company: UnitedHealthcare of Arkansas, Inc.

State Tracking Number: 44401

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: 2009 Federal Form Filing

Project Name/Number: /

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	12/29/2009
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Application	Approved-Closed	12/29/2009
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	12/29/2009
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Outline of Coverage	Approved-Closed	12/29/2009
Bypass Reason:	N/A		
Comments:			
Satisfied - Item:	Cover Letter	Approved-Closed	12/29/2009
Comments:			
Attachment:			
2009 9H_SBN Choice 12.22.09 revision cover.pdf			



December 22, 2009

Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas 72201

Re: UnitedHealthcare of Arkansas Inc.
NAIC No. 95446 United Healthcare of Arkansas, Inc. ®
Group Health Form POL.H.09.AR et al.,

Dear Ms. Minor:

On behalf of UnitedHealthcare of Arkansas Inc., I am submitting the enclosed group health form for your Department's review and approval. This form was included with the 2009 Federal Form Filing, identified by form number POL.H.09.AR et al., which was recently approved by your office October 30, 2009. This document contains a minor revision outlined below, that requires your approval. I would like to reiterate that this form is based on our 2007 Series documents filed and approved in your state. Our intent is to use this form for large and small employer groups. Because the enclosed form has been modified to reflect the laws and regulations of Arkansas, it will not be filed with Connecticut, our State of Domicile. Once approved, this filing and the approved filing referenced in this letter will be used in conjunction with all forms filed and approved for use with our 2007 Series forms. The revision to this form is outlined below.

SBN.CHC.H.09.AR

- Added the [Yes] [No] options for the columns which read "Apply to the Out of Pocket Maximum" and "Must you meet Annual Deductible" to the In Vitro Fertilization Benefit.

This submission has been submitted electronically via SERFF and UnitedHealthcare of Arkansas, Inc. recognizes that we may not implement this form until and unless approval has been granted. Should the Department have any immediate concerns or questions regarding this submission, please feel free to contact me at 240.632.8056, through the SERFF messaging system or at Ebony_N_Terry@uhc.com.

Sincerely,

Ebony N. Terry
Compliance Analyst