

SERFF Tracking Number:	UHLC-126253936	State:	Arkansas
Filing Company:	United HealthCare Insurance Company	State Tracking Number:	43119
Company Tracking Number:			
TOI:	H21 Health - Other	Sub-TOI:	H21.000 Health - Other
Product Name:	2009 AR Fed Forms Revisions		
Project Name/Number:	/		

Filing at a Glance

Company: United HealthCare Insurance Company

Product Name: 2009 AR Fed Forms Revisions SERFF Tr Num: UHLC-126253936 State: Arkansas
 TOI: H21 Health - Other SERFF Status: Closed-Approved- State Tr Num: 43119
 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: 08/14/2009
 Date Submitted: 08/04/2009 Disposition Status: Approved-Closed
 Implementation Date: Implementation Date:

Implementation Date Requested: On Approval

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: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 08/14/2009	Explanation for Other Group Market Type:
	State Status Changed: 08/14/2009
Deemer Date:	Created By: Ebony Terry
Submitted By: Ebony Terry	Corresponding Filing Tracking Number:
Filing Description:	
This submission consists of minor revisions to previously approved forms filed with the 2009 Federal Legislation Form Filing approved July 6, 2009. Please see details of the revisions within the cover letter submitted with this submission. These forms are being filed to replace the previously approved forms.	

Company and Contact

Filing Contact Information

Ebony Terry, Compliance Analyst	Ebony_N_Terry@uhc.com
4 Taft Court	301-838-5611 [Phone]

SERFF Tracking Number: UHLC-126253936 State: Arkansas
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Project Name/Number: /
 Rockville, MD 20850 301-838-5676 [FAX]

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$150.00
 Retaliatory? No
 Fee Explanation: three forms X 50.00 fee.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United HealthCare Insurance Company	\$150.00	08/04/2009	29613193

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/14/2009	08/14/2009

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Disposition

Disposition Date: 08/14/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: UHLC-126253936

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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	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes

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Form Schedule

Lead Form Number: SBN.CHP.I.09.AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	SBN.CHP.I.09.AR	Schedule	Schedule of Benefits	Initial			X09I_SBN_C HCPLS_final.pdf
08/14/2009							
Approved-Closed	SBN.OPT.I.09.AR	Schedule	Schedule of Benefits	Initial			X09I_SBN_O PT.pdf
08/14/2009							
Approved-Closed	SBN.NDF.I.09.AR	Schedule	Schedule of Benefits	Initial			X09I_SBN_N ONDIFF.pdf
08/14/2009							

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

¹Include here and in the header for the Schedule of Benefits table if the plan design provides Designated Network Benefits in any benefit category.

You can choose to receive [¹Designated Network Benefits,] Network Benefits or Non-Network Benefits.

[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.]

¹Include and delete #2 if RAPLs are paid under the facility charge.

²Include and delete #1 if RAPLs are paid under the physician fee (inpatient/outpatient) category.

[¹**Network Benefits** apply to Covered Health Services that are provided by a Network Physician or other Network provider. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility under the direction of either a Network or non-Network Physician or other provider. Network 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 are always paid as Network Benefits.]

[²**Network Benefits** apply to Covered Health Services that are provided by a Network Physician or other Network provider. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility. Emergency Health Services, including the services of either a Network or non-Network Emergency room Physician, are always paid as Network Benefits.]

²Include when RAPLs are paid under the physician fee (inpatient/outpatient) category.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

[²Covered Health Services provided in a Network facility by a non-Network consulting Physician, anesthesiologist, pathologist and radiologist will be paid as Non-Network Benefits.]

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.]

¹Always include unless the Shared Savings Program does not apply to Benefits under this COC. "Shared Savings Program" is bracketed to accommodate possible name change.

Depending on the geographic area and the service you receive, you may have access [¹through our [Shared Savings Program]] to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less [¹when you

receive Covered Health Services from [Shared Savings Program] providers than from other non-Network providers] because the Eligible Expense may be a lesser amount.

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 Network 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.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying us before you receive these services.

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.

Include when group purchases benefits for clinical trials.

- [Clinical trials.]

Include when group purchases benefits for congenital heart disease surgery.

- [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 does not purchase benefits for durable medical equipment.¹ Include if notification applies only to insulin pumps that exceed a specific dollar amount and insert appropriate dollar amount.

- [Diabetes equipment - insulin pumps [¹over \$[1,000 - 5,000]].]

Include when group purchases benefits for DME.¹ Include if notification applies only to DME that exceeds a specific dollar amount and insert appropriate dollar amount.

- [Durable Medical Equipment [¹over \$[1,000 - 5,000]].]

Include when notification is required for home health care.

- [Home health care.]

Include when notification is required for hospice care.

- [Hospice care - inpatient.]

¹Include when full maternity benefits are sold. ²Include when complications of pregnancy benefits are sold.

- Hospital inpatient care - all scheduled admissions [¹and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery] [²and stays for Complications of Pregnancy exceeding 96 hours for a cesarean section delivery].

Include when group purchases benefits for infertility services.

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

Include when notification is required for Lab/X-ray.

- [Lab, X-ray and diagnostics - sleep studies.]

Include when notification is required for Lab/X-ray-Major Diagnostics.

- [Lab, X-ray and major diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine.]

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.]

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

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

Include when notification is required for IV infusions.

- [Pharmaceutical Products - IV infusions only.]

Include when notification is required for select Pharmaceutical Products.

- [Certain Pharmaceutical Products. You may determine whether a particular Pharmaceutical Product requires notification through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

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

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

¹Include when group purchases benefits for breast reduction surgery.

- Reconstructive procedures [¹, including breast reduction surgery].

Include when group purchases benefits for rehabilitation services and when notification is required for any service. ¹Include when Manipulative Treatment is included in the rehabilitation services benefit.

- [Rehabilitation services [¹and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [¹Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [vision therapy].]

Include when notification is required for scopic procedures.

- [Scopic procedures - outpatient diagnostic and therapeutic.]
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.

Include when notification is required for outpatient surgeries.

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators]].]

Include when group purchases benefits for TMJ services and notification is required.

- [Temporomandibular joint services.]

Include when notification is required for outpatient therapeutics.

- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] hyperbaric oxygen therapy].]
- Transplants.

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

¹Include if Mental Health Benefits are sold.

²Include 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.]

For all other services, when you choose to receive services from non-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

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. ^{1-A}Include 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 this *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.]

¹*Include here and in the header for the Schedule of Benefits table if the plan design provides Designated Network Benefits in any benefit category.*

When Benefit limits apply, the limit stated refers to any combination of [¹Designated Network Benefits,] Network Benefits and Non-Network 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	
¹ <i>Include when the Annual Deductible applies only to Non-</i>	¹ <i>Include separate Network and Non-</i>

Network Benefits.

²Include when an Outpatient Prescription Drug Rider is sold and the Annual Deductible applies to any combination of medical and RX benefits.

³Include when an Outpatient Prescription Drug Rider with separate Copayments for preventive medications is sold and the Annual Deductible does not apply to preventive medications.

⁴Include 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.

⁵Include when there is a deductible for Designated and Network Benefits and the network and non-network amounts apply to the Designated Network and Network Annual Deductible.

⁶Include bracketed Designated Network reference when Designated Network Benefits apply to any category.

The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive [¹Non-Network] Benefits. [²The Annual Deductible 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*. [³Benefits for Outpatient Prescription Drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.] [⁴Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the *Outpatient Prescription Drug Rider* are not subject to payment of the Annual Deductible.] [⁵The Annual Deductible for [⁶Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the *Outpatient Prescription Drug Rider*.]

Include when day/visit limits are reduced by the number of days/visit used toward meeting the deductible.

[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.]

Include when dollar limits are reduced by the amount used toward meeting the deductible.

[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.]

Include when the carry-over provision applies.

Network headings and statements when Annual Deductible provision applies separately to Network and Non-Network Benefits and delete the combined "Network and Non-Network" provision below.

²Include when Designated Network Benefits apply to any category.

[¹ [² Designated Network and] Network]

Include when separate individual and family deductibles apply (non-embedded).

[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.

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.]

Include when individual deductible applies (embedded).

[\$[0 - 15,000] per Covered Person.]

Include when individual (with family maximum) deductible applies (embedded).

[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]

Include when there is no annual deductible for network benefits.

[No Annual Deductible.]

[¹ Non-Network]

Include when separate individual and family deductibles apply (non-embedded).

[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.

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

[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.]

Include paragraph if the roll-over provision applies to a group in any circumstance.

[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.]

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.

[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.]]

The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Include only when a per occurrence deductible applies.

[The Annual Deductible does not include any applicable Per Occurrence Deductible.]

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.]

Include when individual deductible applies (embedded).

[\$[0 - 15,000] per Covered Person.]

Include when individual (with family maximum) deductible applies (embedded).

[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]

Include when there is no annual deductible for network benefits.

[No Annual Deductible.]

¹*Include the combined Network and Non-Network heading and statements when Annual Deductible provision applies separately to combined Network and Non-Network Benefits and delete the separate "Network" and "Non-Network" provisions above.*

²*Include when Designated Network Benefits apply to any category.*

[¹ ² Designated Network,] Network and Non-Network]

Include when separate individual and family deductibles apply (non-embedded).

[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.

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.]

Include when individual deductible applies (embedded).

[\$[0 - 15,000] per Covered Person.]

Include when individual (with family maximum) deductible applies (embedded).

	<p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</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> <ul style="list-style-type: none"> • The applicable Per Occurrence Deductible. • The Eligible Expense.] 	<p>¹<i>Include when Designated Network Benefits apply to either category.</i></p> <p>[[¹ Designated Network and] Network]</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 - 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>[Non-Network]</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 - 2,000] per Inpatient Stay.]</p> <p><i>Include when a per occurrence deductible applies to inpatient hospital</i></p>

	<p><i>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: [\$50 - 800] 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>
Out-of-Pocket Maximum	

¹Include when OOPM includes the Annual Deductible.

²Include when OOPM includes the Per Occurrence Deductible.

³Include when OOPM includes Copayments.

⁴Include when an Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.

⁵Include when there is an OOPM for Designated and Network Benefit and the network and non-network amounts paid under the RX rider apply to the Designated Network and Network OOPM.

⁶Include bracketed Designated Network reference when Designated Network Benefits apply to any category.

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*.] [⁵The Out-of-Pocket Maximum for [⁶Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the *Outpatient Prescription Drug Rider*.]

⁷Include only when the plan design does not apply all Copayments/Coinsurance to the OOPM.

[⁷Copayments 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.

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:

- Any charges for non-Covered Health Services.

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.

- [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.

Include bullet when an Outpatient Prescription Drug Rider is

¹Include separate Network and Non-Network headings and statements when OOPM provision applies separately to Network and Non-Network Benefits and delete the combined "Network and Non-Network" provision below.

²Include when Designated Network Benefits apply to any category.

[¹ [² **Designated Network and** Network]

Include when separate individual and family maximums apply (non-embedded).

[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.

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].]

Include when individual OOPM applies (embedded).

[\$[0 - 45,000] per Covered Person.]

Include when individual (with family maximum) applies (embedded).

[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]

Include when the OOPM includes the Annual Deductible.

[The Out-of-Pocket Maximum includes the Annual Deductible.]

Include when the OOPM does not include the Annual Deductible.

[The Out-of-Pocket Maximum does not include the Annual Deductible.]

Include when the OOPM includes the Per Occurrence Deductible.

[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]

Include when the OOPM does not include the Per Occurrence Deductible.

[The Out-of-Pocket Maximum does not

<p><i>sold and Copayments/Coinsurance do not apply to the overall OOPM.</i></p>	<p>include the Per Occurrence Deductible.]</p>
<ul style="list-style-type: none"> • [Copayments or Coinsurance for Covered Health Services provided under the <i>Outpatient Prescription Drug Rider.</i>] 	<p><i>Include when there is no OOPM.</i></p> <p>[No Out-of-Pocket Maximum.]</p> <p>[¹ Non-Network]</p> <p><i>Include when separate individual and family maximums apply (non-embedded).</i></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><i>Include when individual OOPM applies (embedded).</i></p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p><i>Include when individual (with family maximum) applies (embedded).</i></p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p><i>Include when the OOPM includes the Annual Deductible.</i></p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p><i>Include when the OOPM does not include the Annual Deductible.</i></p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p><i>Include when the OOPM includes the Per Occurrence Deductible.</i></p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p><i>Include when the OOPM does not include the Per Occurrence Deductible.</i></p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p> <p><i>Include when there is no OOPM.</i></p> <p>[No Out-of-Pocket Maximum.]</p> <p>³<i>Include combined Network and Non-Network heading and statements below</i></p>

	<p><i>when OOPM provision applies to combined Network and Non-Network Benefits and delete the separate "Network" and "Non-Network" provisions above.</i></p> <p><i>²Include when Designated Network Benefits apply to any category.</i></p> <p><i>[³[Designated Network,] Network and Non-Network]</i></p> <p><i>Include when separate individual and family maximums apply (non-embedded).</i></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><i>Include when individual OOPM applies (embedded).</i></p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p><i>Include when individual (with family maximum) applies (embedded).</i></p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p><i>Include when the OOPM includes the Annual Deductible.</i></p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p><i>Include when the OOPM does not include the Annual Deductible.</i></p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p><i>Include when the OOPM includes the Per Occurrence Deductible.</i></p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p><i>Include when the OOPM does not include the Per Occurrence Deductible.</i></p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p>
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	<p><i>Include when there is no OOPM.</i> [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<i>Include when separate Network and Non-Network Maximums apply.</i> ²<i>Include when Designated Network Benefits apply to any category.</i></p> <p>[¹ ² Designated Network and Network] [\$[1,000,000 - 10,000,000] per Covered Person.] [No Maximum Policy Benefit.]</p> <p>[¹ Non-Network] [\$[1,000,000 - 10,000,000] per Covered Person.] [No Maximum Policy Benefit.]</p> <p>³<i>Include when combined Network and Non-Network Maximums applies.</i></p> <p>[³ ² Designated Network,] Network and Non-Network] [\$[1,000,000 - 10,000,000] per Covered Person.]</p>
<p><i>Include only when an annual maximum benefit applies.</i> [Annual Maximum Benefit]</p>	

<p>[The maximum amount we will pay for Benefits during the year.]</p>	<p>¹Include when separate Network and Non-Network Maximums apply.</p> <p>²Include when Designated Network Benefits apply to any category.</p> <p>[¹ [² Designated Network and] Network]</p> <p>[\$[2,000 - 500,000] per Covered Person.]</p> <p>[¹ Non-Network]</p> <p>[\$[2,000 - 500,000] per Covered Person.]</p> <p>³Include when combined Network and Non-Network Maximums applies.</p> <p>[³ [² Designated Network,] Network and Non-Network]</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.

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

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

³Include 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.

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

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

³Include 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 refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>[This limit applies to Network Benefits only. Non-Network Benefits are not available.]</p>	<p>[Network]</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>[Non-Network]</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>[Non-Network Benefits are not available.]</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>[Non-Network Benefits are not available.]</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>[Non-Network Benefits are not available.]</p>
<p>[2.] Ambulance Services</p>			
<p align="center">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>Network</p>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>[Ground ambulance limited to \$[500 - 5,000] per year.]</p>	<p>Ground Ambulance:</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>[Yes] [No]</p>	<p>[Yes] [No]</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>Air Ambulance:</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>Non-Network</p> <p>Same as Network</p>	<p>[Yes] [No]</p> <p>Same as Network</p>	<p>[Yes] [No]</p> <p>Same as Network</p>
<p>Non-Emergency Ambulance</p> <p>Ground or air ambulance, as we determine appropriate.</p>	<p>Network</p> <p>Ground Ambulance:</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 -</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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>Non-Network</p> <p>Same as Network</p>	<p>[Yes] [No]</p> <p>Same as Network</p>	<p>[Yes] [No]</p> <p>Same as Network</p>
<p><i>Include for groups that purchase benefits for clinical trials.</i></p> <p>[3.] [Clinical Trials]</p>			
<p><i>When Clinical Trials benefit is included, pre-service notification requirement will always apply.</i></p> <p>[Pre-service Notification Requirement]</p> <p>[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.]</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>Benefits are available when the Covered Health Services are provided by either Network or non-Network</p>	<p>[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>[Non-Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each</p>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)]</p>	<p>Covered Health Service category in this <i>Schedule of Benefits.</i>]</p>		
<p><i>Include for groups that purchase benefits for congenital heart disease services.</i></p> <p>[4.] [Congenital Heart Disease Surgeries]</p>			
<p><i>Include if pre-service notification is required.</i></p> <p>¹<i>Include if Non-Network Benefits are sold and if use of a Designated Facility is required in order to receive Network Benefits.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[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.] [¹Non-Network Benefits will apply.]</p> <p><i>Include when notification is required.</i></p> <p>¹<i>Include applicable reduction in Benefits.</i></p> <p>[For Non-Network Benefits you must notify us as soon as the possibility of a Congenital Heart Disease (CHD) surgery arises. If you don't notify us, Benefits will be reduced to [¹50 - 95]% of Eligible Expenses].</p>			
<p><i>Include when Designated Network Benefits are available.</i></p> <p>[When performed at a Designated Facility as part of the evaluation and treatment of CHD, Covered Health Services include diagnostic services, cardiac catheterization and all non-surgical management of CHD.]</p> <p><i>Include when CHD benefits are sold and when both Network and Non-Network Benefits are available.</i></p> <p>[Network and Non-Network Benefits</p>	<p>[Designated 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 -</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 refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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 in order to receive Network Benefits.</i></p> <p>[For Network Benefits, CHD surgeries must be received at a Designated Facility.</p> <p>Non-Network Benefits include services provided at a Network facility that is not a Designated Network Facility and services provided at a non-Network facility.</p> <p>Non-Network Benefits under this section include only the 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 Network and Non-Network Benefits are limited and insert the limit selected by the group.</i></p> <p>[Network and Non-Network Benefits are limited to \$[30,000 - 250,000] per CHD surgery.]</p> <p><i>Include when Non-Network Benefits are limited and insert the limit selected by the group.</i></p> <p>[Non-Network Benefits are limited to</p>	<p>1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p>[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>[Non-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</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible is satisfied]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>¹Include when the durable medical equipment benefit is sold.</p> <p>²Include when the durable medical equipment benefit is not sold.</p> <p>³Include when notification applies only to equipment that exceeds a minimum dollar amount and insert applicable dollar amount.</p> <p>⁴Include applicable reduction in Benefits or no Benefits.</p>			
<p style="text-align: center;">Pre-service Notification Requirement</p> <p style="text-align: center;">For Non-Network Benefits you must notify us before obtaining any [¹Durable Medical Equipment] [²diabetes equipment] for the management and treatment of diabetes [³that exceeds \$[1,000 - 5,000] in cost (either purchase price or cumulative rental of a single item)]. If you fail to notify us as required, [⁴Benefits will be reduced to [50 - 95]% of Eligible Expenses] [⁴you will be responsible for paying all charges and no Benefits will be paid].</p>			
<p>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</p>	<p>Network</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>Non-Network</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>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-</p>	<p>Network</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</p>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
five] years].]	<p>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 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> <p>Non-Network</p> <p>¹Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.</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>²Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold.</p> <p>³Include when sold with a plan that has an annual deductible</p>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>and select either "are" or "are not."</i></p> <p>⁴<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>²<i>For diabetes equipment, Benefits will be the same as those stated under 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 the Annual Deductible]. [⁴Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]</p> <p>⁵<i>Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold.</i></p> <p>⁶<i>Include when sold with a plan that has an annual deductible and select either "are" or "are not."</i></p> <p>⁷<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>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>⁸<i>Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold.</i></p> <p>⁹<i>Include when sold with a plan that has an annual deductible and select either "are" or "are not."</i></p> <p>¹⁰<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>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>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 DME.</i></p> <p>[7.] [Durable Medical Equipment]</p>			
<p>¹Include when notification applies only to DME that exceeds a minimum dollar amount and insert applicable dollar amount.</p> <p>²Include applicable reduction in Benefits or no Benefits.</p>			
<p align="center">[Pre-service Notification Requirement]</p> <p>[For Non-Network Benefits you must notify us before obtaining any Durable Medical Equipment [¹that exceeds \$[1,000 - 5,000] in cost (either purchase price or cumulative rental of a single item)]. 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>			
<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 includes disposable supplies necessary for the effective use of covered Durable Medical Equipment.] • [\$[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>¹Include when Benefits are provided for speech aid and tracheo-</p>	<p>[Network]</p> <p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>esophageal voice devices.</i></p> <p>²<i>Include 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>[To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.]</p>	<p>[Non-Network]</p> <p>[[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<p>[8.] Emergency Health Services - Outpatient</p>			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.</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</i> 	<p>Network</p> <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>[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 refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>Nuclear Medicine - Outpatient.]</i></p> <ul style="list-style-type: none"> • [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>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 [and Manipulative Treatment].]</i>] 	<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] 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>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 if plan design includes retrospective review of emergency services.</i></p> <p>[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> <p>Non-Network Same as Network</p>	Same as Network	Same as Network
<p><i>Include as standard only for groups of 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 \$[500 - 5,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[two-five] years].]</p>	<p>[Network] [[50 - 100]%</p> <p>[Non-Network] [[50 - 100]%</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>
<p>[10.] Home Health Care</p>			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 if pre-service notification is required.</i></p> <p>¹<i>Include applicable reduction in Benefits.</i></p>			
<p align="center">[Pre-service Notification Requirement]</p> <p>[For Non-Network Benefits you must notify us five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [150 - 95]% of Eligible Expenses.]</p> <p><i>Include if pre-admission notification is required.</i></p> <p>[In addition, for Non-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]</p>			
	<p>Network</p> <p>[[50 - 100]%)</p> <p>[100% after you pay a Copayment of \$[5 - 100] per day]</p> <p>Non-Network</p> <p>[[50 - 100]%)</p> <p>[100% after you pay a Copayment of \$[5 - 100] per day]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>
<p>[12.] Hospital - Inpatient Stay</p>			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 Activation Program is sold.</i></p> <p>¹<i>Include applicable Benefit level.</i></p>			
<p align="center">[Benefit Activation Notification Requirement]</p> <p>[For Network Benefits for Covered Health Services for certain 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 applicable Benefit level.</i></p> <p align="center">Pre-service Notification Requirement</p> <p>For Non-Network Benefits for a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to notify us as required, Benefits will be reduced to [¹50 - 95]% of Eligible Expenses.</p>			
<p><i>Include if pre-admission notification is required.</i></p> <p>[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>			
<p>¹<i>Include heading and 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 	<p>[¹ Designated 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 refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 facility charge [and Physician's fees] for services 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>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>Non-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</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible is satisfied]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 10,000] per Inpatient Stay		
<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, [Benefits 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>¹<i>Include heading and row when Designated Network Benefits apply.</i></p> <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>[¹ Designated Network] [[50 - 100]%</p> <p>[Network] [[50 - 100]%</p> <p>[Non-Network] [[50 - 100]%</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[14.] Lab, X-Ray and Diagnostics - Outpatient			
<p><i>Include when pre-service notification is required for sleep studies.</i></p> <p>¹<i>Include applicable reduction in Benefits.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[For Non-Network Benefits for sleep studies, you must notify us five business days before scheduled services are received. If you fail to notify us as required, Benefits will be reduced to [¹50 - 95]% of Eligible Expenses.]</p>			
<p>¹<i>Include heading and 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>[Non-Network Benefits are 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>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>Non-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>[Yes] [No]</p> <p>[Yes] [No]</p>
[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
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Include when pre-service notification is required for CT, PET, MRI, MRA and nuclear medicine.

¹*Include applicable reduction in Benefits.*

[Pre-service Notification Requirement]

[For Non-Network Benefits you must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [150 - 95]% of Eligible Expenses.]

¹ <i>Include heading and row when Designated Network Benefits apply.</i> <i>Include limit selected by group.</i> [Limited to \$[100 - 5,000] per year.] [Non-Network Benefits are limited to \$[100 - 5,000] per year.]	¹ Designated Network [[50 - 100]%] [100% after you pay a Copayment of \$[25 - 500] per service] Network [[50 - 100]%] [100% after you pay a Copayment of \$[25 - 500] per service] Non-Network [[50 - 100]%] [100% after you pay a Copayment of \$[25 - 500] per service]	[Yes] [No] [Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No] [Yes] [No]
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Include for groups that purchase Mental Health benefits. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. Remove entire benefit if group purchases MH full parity.

¹*Include if group purchases SA benefits.*

[16.] Mental Health Services

When this benefit is purchased, prior authorization will always be required.

¹*Include as standard when parity applies.*

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 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].]			
<p>Note: When the underlying medical plan does not apply visit or day limits, limits are permitted only for small business (50 and fewer) or for non-ERISA groups that choose to be exempt from Parity requirements. Include the limit selected by the group.</p> <p>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."</p>	<p>[Network]</p> <p>[Inpatient/Intermediate] [Yes] [No]</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>Select from these limit options when limits apply only to Mental Health Services described in this section.</p> <p>[Inpatient/Intermediate Mental Health Services are limited to [10 - 100] days per year.]</p> <p>[Outpatient Mental Health Services are limited to [10 - 100] visits per year.]</p> <p>[Non-Network Benefits for Inpatient/Intermediate Mental Health Services are limited to [10 - 100] days per year.]</p> <p>[Non-Network Benefits for outpatient Mental Health Services are limited to [10 - 100] visits per year.]</p>	<p>[Outpatient]</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>[Non-Network]</p> <p>[Inpatient/Intermediate] [Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 to Mental Health Services described in this section combined with Neurobiological Disorders - Autism Spectrum Disorders below.</i></p> <p>[Benefits for any combination of Mental Health Services described in this section and Neurobiological Disorders - Autism Spectrum Disorders described below are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for Inpatient/Intermediate Mental Health Services and Neurobiological Disorders - Autism Spectrum Disorders. [10 - 100] visits per year for outpatient Mental Health Services and Neurobiological Disorders - Autism Spectrum Disorders.] 	<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 to Mental Health Services described in this section combined with Substance Use Disorder Services below.</i></p> <p>[Benefits for any combination of Mental Health Services described in this section and Substance Use Disorder Services described below 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>[Outpatient]</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>	[Yes] [No]	[Yes] [No]
<p>Note: When parity applies, these benefit statements must be used in lieu of those options available above to</p>	<p>[Network]</p> <p>[Depending upon where the Covered Health Service is</p>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>assure that cost sharing will always be equal to medical services.</i></p>	<p>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>[Non-Network]</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</i></p>	<p>[Network] <i>[Inpatient/Intermediate]</i></p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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 Neurobiological Disorders - Autism Spectrum Disorders described in this section.</i></p> <p>[Inpatient/Intermediate Neurobiological Disorders -Autism Spectrum Disorders are limited to [10 - 100] days per year.]</p> <p>[Outpatient Neurobiological Disorders - Autism Spectrum Disorders are limited to [10 - 100] visits per year.]</p> <p>[Non-Network Benefits for Inpatient/Intermediate Neurobiological Disorders -Autism Spectrum Disorders are limited to [10 - 100] days per year.]</p> <p>[Non-Network Benefits for outpatient Neurobiological Disorders -Autism Spectrum Disorders are limited to [10 - 100] visits per year.]</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>[Benefits for any combination of Neurobiological Disorders - Autism</p>	<p>[Outpatient]</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>[Non-Network]</p> <p>[Inpatient/Intermediate]</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</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>Spectrum Disorders</i> described in this section and <i>Mental Health Services</i> described above are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for Inpatient/Intermediate <i>Neurobiological Disorders - Autism Spectrum Disorders</i> and <i>Mental Health Services</i>. [10 - 100] visits per year for outpatient <i>Neurobiological Disorders - Autism Spectrum Disorders</i> and <i>Mental Health Services</i>.] 	<p>Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p>		
	<p>[Outpatient] [[50 - 100]%] [100% after you pay a Copayment of \$[5 - 100] per visit] [100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.] [100% for visits for medication management]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<p>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.</p>	<p>[Network] [Depending upon where the Covered Health Service is provided, Benefits for outpatient <i>Neurobiological Services - Autism Spectrum 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>Neurobiological Services - Autism Spectrum Disorder Services</i> will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>.] [Include when outpatient visits for medication management are paid at 100%.] [Benefits for outpatient visits for medication management will be paid at 100%.]</p>		
	<p>[Non-Network]</p>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>[Depending upon where the Covered Health Service is provided, Benefits for outpatient <i>Neurobiological Services - Autism Spectrum 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>Neurobiological Services - Autism Spectrum 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><i>Include for groups that purchase benefits for obesity surgery.</i></p> <p>[18.] [Obesity Surgery]</p>			
<p><i>When this benefit is purchased, pre-service notification will always be required. ¹Include applicable Benefit level.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[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 [¹50 - 95]% of Eligible Expenses.]</p> <p><i>Include if pre-admission notification is required.</i></p> <p>[In addition, for Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.]</p> <p>[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.]</p>			
<p>¹<i>Include heading and row when Designated Network Benefits apply.</i></p> <p>²<i>Include when Designated Network Benefits apply.</i></p> <p>³<i>Include when Network Benefits are available.</i></p> <p>⁴<i>Insert the limit selected by the group.</i></p> <p>[Any combination of [²Designated Network Benefits] [³, Network Benefits] and Non-Network Benefits is limited to \$[⁴50,000 - 250,000] during the entire</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>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>period of time a Covered Person is enrolled for coverage under the Policy. Non-Network Benefits are further limited to \$[45,000 - 30,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]</p> <p><i>Include when there is not a Network level of benefits available.</i></p> <p>[Non-Network Benefits include services provided at a Network facility that is not a Designated Network Facility and services provided at a non-Network facility.]</p>	<p>[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>[Non-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><i>Include if group purchases benefits for ostomy supplies.</i></p> <p>[19.] [Ostomy Supplies]</p>			
<p><i>Include the limit selected by the group.</i></p> <p>[Limited to \$[500 - 25,000] per year.]</p>	<p>[Network]</p> <p>[[50 - 100] %]</p> <p>[Non-Network]</p> <p>[[50 - 100] %]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>
<p>[20.] Pharmaceutical Products - Outpatient</p>			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 notification is required for IV infusions.</i></p> <p>¹<i>Include applicable reduction in Benefits.</i></p>			
<p>[Pre-service Notification Requirement]</p> <p>[For Non-Network Benefits you must notify us five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [150 - 95]% of Eligible Expenses.]</p> <p><i>Include when notification is required for select Pharmaceutical Products.</i></p> <p>[For Non-Network Benefits you must notify us five business days before certain pharmaceutical products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [150 - 95]% of Eligible Expenses. You may determine whether a particular Pharmaceutical Product requires notification through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>			
<p>¹<i>Include heading and 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>[Non-Network Benefits are 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 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]</p> <p>[[50 - 100]% - Tier 2]</p> <p>[[50 - 100]% - Tier 3]</p> <p>[[50 - 100]% - Tier 4]</p> <p>[[50 - 100]% - Tier 5]</p> <p>[[50 - 100]% - Tier 6]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per</p>	<p>[Yes] [No]</p> <p>[Yes, except when provided during a Physician office visit]</p> <p>[Yes] [No]</p> <p>[Yes, except when provided during a</p>	<p>[Yes] [No]</p> <p>[Yes, except when provided during a Physician office visit]</p> <p>[Yes] [No]</p> <p>[Yes, except when provided during a Physician office</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 Activation Program is sold.</i></p> <p>¹<i>Include applicable Benefit level.</i></p>			
<p>[Benefit Activation Notification Requirement]</p> <p>[For Network Benefits 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 heading and 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.] 	<p>[¹ Designated Network]</p> <p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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"> • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [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 Customer Care at the telephone number on your ID card.]</p> <p>²Include text if the plan design supports paying non-network benefits for a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist).</p> <p>[²Covered Health Services provided by a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist) in a Network facility will be paid as Non-Network Benefits.]</p> <p>³Include text if the plan design supports paying non-network benefits for a non-Network consulting Physician, assistant surgeon or surgical assistant.</p> <p>[³Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical</p>	<p>Network</p> <p>[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>assistant in a Network facility will be paid as Non-Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.]</p>	<p>Non-Network [50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<p>[22.] Physician's Office Services - Sickness and Injury</p>			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 Activation Program is sold.</i> ¹<i>Include applicable Benefit level.</i></p>			
<p>[Benefit Activation Notification Requirement]</p> <p>[For Network Benefits 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>¹<i>Include heading and row when Designated Network Benefits apply.</i></p> <p><i>Include when enhanced benefits apply to specific physician office 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.] 	<p>[¹ Designated 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</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 refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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"> [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 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 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>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>		
<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</i></p>	<p>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]</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 refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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 - Outpatient.</i>] • [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 [1 and Manipulative Treatment].</i>] 	<p>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> <p>Non-Network</p>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>[[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 - 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</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 refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[#] visits in a year; [50 - 90]% for any subsequent visits in that year]		
<p>¹Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude. ²If Maternity Services are excluded, Complications of Pregnancy must always be included.</p> <p>[23.] Pregnancy - [¹Maternity Services] [²Complications of Pregnancy only]</p>			
<p>¹Include when benefits are provided for maternity services. ²Include applicable Benefit level.</p> <p style="text-align: center;">[¹Pre-service Notification Requirement]</p> <p>[¹For Non-Network Benefits you must notify us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to notify us as required, Benefits will be reduced to [²50 - 95]% of Eligible Expenses.]</p> <p>³Include when benefits are provided for complications of pregnancy only. ⁴Include applicable Benefit level.</p> <p style="text-align: center;">[³Pre-service Notification Requirement]</p> <p>[³For Non-Network Benefits you must notify us five business days before admission for scheduled admissions or within one business day or the same day, or as soon as is reasonably possible for non-scheduled admissions. If you fail to notify us as required, Benefits will be reduced to [⁴50 - 95]% of Eligible Expenses.]</p> <p style="text-align: center;">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>[¹ Network]</p> <p>³Include when an annual deductible applies to network benefits.</p> <p>⁴Include when Network 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</p>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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>[¹ Non-Network]</p> <p>³Include when an annual deductible applies to non-network benefits.</p> <p>⁴Include when Non-Network 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> <p>[² Network]</p> <p>[²Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p> <p>[² Non-Network]</p> <p>[²Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>		
[24.] Preventive Care Services			
<p><i>Include when preventive care is limited and select the limit that applies.</i></p> <p>[Preventive care services are limited to \$[100 - 1,000] per year.]</p> <p>Physician office services</p> <p>Well baby and well child care includes, but is 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,</p>	<p>Network</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</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 refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>16 years, and 18 years.</p> <p>No Copayment, Coinsurance or deductible will be applicable to Network or non-Network children's immunizations.</p>	<p>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>Non-Network</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>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not available.]</p>
<p>Lab, X-ray or other preventive tests:</p>	<p>Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 - 100] per service] Non-Network [[50 - 100]%] [100% after you pay a Copayment of \$[5 - 100] per service] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]
<i>Include when group purchases benefits for prosthetic devices. Prosthetics are a mandated benefit in Arkansas.</i>			
[25.] Prosthetic Devices and Services			
<i>Include if notification is required.</i>			
¹ Include when notification applies only to prosthetics that exceed a minimum dollar amount and insert applicable dollar amount.			
² Include applicable reduction in Benefits or no Benefits.			
[Pre-service Notification Requirement] [For Non-Network Benefits you must notify us before obtaining prosthetic devices ¹ that exceed \$[1,000 - 5,000] in cost per device]. If you fail to notify us as required, ² Benefits will be reduced to [50 - 95]% of 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.	[Network] [[50 - 100]%] [Non-Network] [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[26.] Reconstructive Procedures			
¹ Include applicable Benefit level.			
Pre-service Notification Requirement For Non-Network Benefits you must notify us five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [50 - 95]% of Eligible			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Expenses.			
<i>Include if pre-admission notification is required.</i>			
[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]			
	<p>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><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>Non-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><i>Include when group does not purchase benefits for prosthetic devices. The Benefit level inserted here must be the same as the plan Coinsurance level.</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>		
<i>Include entire section when</i>			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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 notification is required for any rehabilitation service.</i></p> <p>¹<i>Include applicable Benefit level.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[For Non-Network Benefits you must notify us five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [vision therapy] or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [¹50 - 95]% of Eligible Expenses.]</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 Treatment.] • [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 	<p>[Network]</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>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>therapy.]]</p> <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, occupational therapy, [¹Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [²and vision therapy] is limited to \$[750 - 12,000] per year.]</p> <p><i>Include when combined therapy visit limits apply separately to network benefits and to non-network benefits.</i></p>	<p>[Non-Network]</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>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>¹Include 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.</p> <p>²Include when vision therapy benefits are sold.</p> <p>[Network Benefits for 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] are limited to [10 - 160] visits per year.]</p> <p>[Non-Network Benefits for 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] are limited to [10 - 160] visits per year.]</p>			
<p>[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic</p>			
<p><i>Include when notification is required for scopic procedures.</i></p>			
<p>¹Include applicable Benefit level.</p>			
<p align="center">[Pre-service Notification Requirement]</p>			
<p>[For Non-Network Benefits you must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [¹50 - 95]% of Eligible Expenses.]</p>			
<p>¹Include heading and row when Designated Network Benefits apply.</p>	<p>[¹ Designated Network] [[50 - 100]% Network</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[50 - 100]% Non-Network [50 - 100]%	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
<p>¹<i>Include applicable Benefit level.</i></p> <p style="text-align: center;">Pre-service Notification Requirement</p> <p>For Non-Network Benefits for a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to notify us as required, Benefits will be reduced to [¹50 - 95]% of Eligible Expenses.</p> <p><i>Include if pre-admission notification is required.</i></p> <p>[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>			
<p><i>Include limit selected by group.</i></p> <p>[Limited to [40 - 180] days per year.]</p> <p>[Network Benefits are limited to [40 - 180] days per year. Non-Network Benefits are limited to [40 - 180] days per year.]</p>	<p>Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[50 - 1,000] per day]</p> <p><i>Copayment option below identified as #1 to be tied only to either of the options #1 below with an Inpatient Stay maximum.</i></p> <p>[¹100% after you pay a Copayment of \$[50 - 2,000] per Inpatient Stay]</p> <p>[¹100% after you pay a Copayment of \$[50 - 1,000] per day to a maximum Copayment of \$[50 - 5,000] per Inpatient Stay]</p> <p><i>Variable #1 can be</i></p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>used only with options 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>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[50 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[50 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[50 - 1,000] per day to a maximum Copayment of \$[50 - 10,000] per Inpatient Stay]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 substance use disorder benefits. Include ONLY when group purchases plan with outpatient SA benefits with MH full parity or no MH. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing</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 align="center"><i>[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].]</i></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>[Network]</p> <p><i>[Inpatient/Intermediate]</i></p> <p><i>[[50 - 100]%]</i></p> <p><i>[100% after you pay a Copayment of \$[100 - 1,000] per day]</i></p> <p><i>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</i></p> <p><i>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</i></p>	<p><i>[Yes] [No]</i></p>	<p><i>[Yes] [No]</i></p>
<p><i>Select from these limit options when limits apply only to Substance Use Disorder Services described in this</i></p>	<p><i>[Outpatient]</i></p> <p><i>[[50 - 100]%]</i></p> <p><i>[100% after you pay a</i></p>	<p><i>[Yes] [No]</i></p>	<p><i>[Yes] [No]</i></p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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>[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>	[Yes] [No]	[Yes] [No]
<p>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.</p>	<p>[Network]</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>[Non-Network]</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</p>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 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>		
[31.] Surgery - Outpatient			
<p><i>Include when Benefit Activation Program is sold.</i></p>			
<p>¹<i>Include applicable Benefit level.</i></p>			
<p>[Benefit Activation Notification Requirement]</p>			
<p>[For Network Benefits 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><i>Include when notification is required.</i></p>			
<p>¹<i>Include applicable Benefit level.</i></p>			
<p>[Pre-service Notification Requirement]</p>			
<p>[For Non-Network Benefits [for all outpatient surgeries] [for [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators]] you must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
<p>¹<i>Include heading and row when Designated Network Benefits apply.</i></p>	<p>[¹ Designated Network]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<p><i>Include provision below when enhanced benefits apply to specific outpatient surgical services.</i></p>	<p>[[50 - 100]%]</p>		<p>[Yes, after the Per Occurrence Deductible is satisfied]</p>
<p>²<i>Include when Physician's fees are paid under the facility charge.</i></p>	<p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service]</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 	<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>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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].]]</p> <ul style="list-style-type: none"> [The Coinsurance you pay for the facility charge [and 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>[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>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>Non-Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible is satisfied]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year]]		
<p><i>Include when group purchases TMJ benefit. This is a mandated benefit in Arkansas.</i></p> <p>[32.] [Temporomandibular Joint Services]</p>			
<p><i>When this benefit is purchased, pre-service notification will always be required.</i></p> <p>¹<i>Include applicable Benefit level.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[For Non-Network Benefits you must notify us five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to notify us as required, Benefits will be reduced to [150 - 95]% of Eligible Expenses.]</p> <p><i>Include if pre-admission notification is required.</i></p> <p>[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions.]</p>			
<p><i>Include the limit selected by the group.</i></p> <p>[Limited to \$[1,000 - 20,000] per year.]</p>	<p>[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>[Non-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>[33.] Therapeutic Treatments - Outpatient</p>			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 notification is required.</i> ¹<i>Include applicable Benefit level.</i></p>			
<p>[Pre-service Notification Requirement]</p> <p>[For Non-Network Benefits you must notify us [for all outpatient therapeutic services] [for the following outpatient therapeutic services] five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [Services that require notification: [dialysis] [,] [and] chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [hyperbaric oxygen therapy].] If you fail to notify us as required, Benefits will be reduced to [¹50 - 95]% of Eligible Expenses.]</p>			
<p>¹<i>Include heading and row when Designated Network Benefits apply.</i></p>	<p>¹ Designated Network [[50 - 100]% [100% after you pay a Copayment of \$[25 - 100] per treatment]</p> <p>Network [[50 - 100]% [100% after you pay a Copayment of \$[25 - 100] per treatment]</p> <p>Non-Network [[50 - 100]% [100% after you pay a Copayment of \$[25 - 100] per treatment]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>
<p>[34.] Transplantation Services</p>			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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>[Non-Network Benefits are not available.]</p>		available.]
[35.] Urgent Care Center Services			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 urgent care services are limited and insert the limit selected by the group.</i></p> <p>[Limited to \$[100 - 5,000] per year.] [Limited to [2 - 10] visits per year.]</p> <p><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 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 -</i> 	<p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit to a maximum Copayment of \$[5 - 5,000] per year]</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 - 150] 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 refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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> <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>Non-Network</p> <p><i>[[50 - 100]%</i></p> <p><i>[100% after you pay a Copayment of \$[5 - 150] per visit]</i></p> <p><i>[100% after you pay a Copayment of \$[5 - 150] per visit to a maximum Copayment of \$[5 - 5,000] per year]</i></p> <p><i>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</i></p> <p><i>[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]</i></p>	<p><i>[Yes] [No]</i></p> <p><i>[Yes, when Benefits are subject to Coinsurance]</i></p>	<p><i>[Yes] [No]</i></p> <p><i>[Yes, when Benefits are subject to Coinsurance]</i></p>
<p><i>Include when group purchases benefits for vision exams.</i></p> <p>[36.] [Vision Examinations]</p>			
<p><i>[Limited to [1 exam] [[2-3] exams] per year.]</i></p> <p><i>[Limited to [1 exam] [[2-3] exams]</i></p>	<p>[Network]</p> <p><i>[[50 - 100]%</i></p>	<p><i>[Yes] [No]</i></p>	<p><i>[Yes] [No]</i></p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
every [2 - 3] years.]	<p>[100% after you pay a Copayment of [\$5 - 75] per visit]</p> <p>[Non-Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of [\$5 - 75] per visit]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>
<p><i>Include when group purchases benefits for wigs.</i></p> <p>[37.] [Wigs]</p>			
<p><i>Include the limit selected by the group.</i></p> <p>[Limited to \$[100 - 1,000] per year.]</p> <p>[Limited to \$[100 - 5,000] every [24 - 36] months.]</p>	<p>[Network]</p> <p>[[50 - 100]%</p> <p>[Non-Network]</p> <p>[[50 - 100]%</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>
<p>Additional Benefits Required By Arkansas Law</p>			
<p>[38.] Dental Services - Anesthesia and Hospitalization</p>			
<p style="text-align: center;">Pre-service Notification Requirement</p> <p>Any applicable notification requirements will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>.</p>			
<p>¹<i>Include heading and row when Designated Network Benefits apply.</i></p>	<p>[¹ Designated Network]</p> <p>[Benefits will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>.]</p> <p>Network</p> <p>Benefits will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
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 Include applicable reduction in Benefits or no Benefits.			
<p style="text-align: center;">Pre-service Notification Requirement</p> <p>You must notify us as soon as the possibility of the need for in vitro fertilization arises. If you fail to notify us as required, [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 heading and row when Designated Network Benefits apply</i></p> <p>Limited to a lifetime maximum of \$15,000.</p>	<p>[¹ Designated Network [50 - 100%]</p> <p>Network [50 - 100%]</p> <p>Non-Network [[50 - 100]%</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>
[40.] Medical Foods			
	<p>¹Include when group purchases the <i>Outpatient Prescription Drug Rider</i>.</p> <p>Network Depending upon where the Covered Health Service is provided, Benefits will be [50 - 100]% [¹or as provided under the <i>Outpatient Prescription Drug Rider</i>].</p> <p>Non-Network Same as Network</p>	<p>[Yes] [No]</p> <p>Same as Network</p>	<p>[Yes] [No]</p> <p>Same as Network</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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>[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>[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>[Non-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>[42.] Orthotic Devices and Services</p>			
<p><i>Include if notification is required.</i></p> <p>¹<i>Include when notification applies only to orthotics that exceed a minimum dollar amount and insert applicable dollar amount.</i></p> <p>²<i>Include applicable reduction in Benefits or no Benefits.</i></p>			
<p 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>			
<p>Benefits for replacements are limited to a single purchase of each type of orthotic device every three years.</p>	<p>Network</p> <p>[50 - 100%]</p> <p>Non-Network</p> <p>[50 - 100%]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>

Eligible Expenses

¹*Include when Designated Network Benefits apply for any Covered Health Service.*

Eligible Expenses are the amount we determine that we will pay for Benefits. For [¹Designated Network Benefits and] Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. 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.

¹*Include when group purchases MH benefits.* ²*Include 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.]

For [¹Designated Network Benefits and] Network Benefits, Eligible Expenses are based on either of the following:

- 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 state law].

For Non-Network Benefits, Eligible Expenses are based on either of the following:

Include the provisions that apply for determining Eligible Expenses for Non-Network Benefits.

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, [at our discretion,] based on [the lesser of]:

¹*When using PHCS to determine Eligible Expenses for Non-Network Benefits, include the following and delete MNRP provisions.*

- [¹For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
- When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [____]% of the amount that the *Centers for Medicare and Medicaid Services (CMS)* would have paid under the Medicare program for the drug determined by either of the following:
 - ◆ Reference to available CMS schedules.
 - ◆ Methods similar to those used by CMS.
- Fee(s) that are negotiated with the provider.
- [50 - 100]% of the billed charge.
- A fee schedule that we develop.]

²*When using MNRP to determine Eligible Expenses for Non-Network Benefits, include the following and delete PHCS provisions.*

- [²Fee(s) that are negotiated with the provider.

- []% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service [within the geographic market].
 - [50 - 100]% of the billed charge.
 - A fee schedule that we develop.]
- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

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.

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.

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.

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, Network 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, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network 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, Covered Health Services will be paid as Non-Network Benefits.

UnitedHealthcare [Options PPO]

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

¹Include here and in the header for the Schedule of Benefits table if the plan design provides Designated Network Benefits in any benefit category.

You can choose to receive [¹Designated Network Benefits,] Network Benefits or Non-Network Benefits.

[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.]

¹Include and delete #2 if RAPLs are paid under the facility charge.

²Include and delete #1 if RAPLs are paid under the physician fee (inpatient/outpatient) category.

[¹**Network Benefits** apply to Covered Health Services that are provided by a Network Physician or other Network provider. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility under the direction of either a Network or non-Network Physician or other provider. Network 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 are always paid as Network Benefits.]

[²**Network Benefits** apply to Covered Health Services that are provided by a Network Physician or other Network provider. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility. Emergency Health Services, including the services of either a Network or non-Network Emergency room Physician, are always paid as Network Benefits.]

²Include when RAPLs are paid under the physician fee (inpatient/outpatient) category.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

[²Covered Health Services provided in a Network facility by a non-Network consulting Physician, anesthesiologist, pathologist and radiologist will be paid as Non-Network Benefits.]

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.]

¹Always include unless the Shared Savings Program does not apply to Benefits under this COC. "Shared Savings Program" is bracketed to accommodate possible name change.

Depending on the geographic area and the service you receive, you may have access [¹through our [Shared Savings Program]] to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less [¹when you

receive Covered Health Services from [Shared Savings Program] providers than from other non-Network providers] because the Eligible Expense may be a lesser amount.

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

¹*Include when Network providers are responsible for notification for Network Benefits.*

We require notification before you receive certain Covered Health Services. [¹In general, Network providers are responsible for notifying us before they provide these services to you. There are some Network 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.

¹*Include when the Covered Person is responsible for notification for Network Benefits.*

When you choose to receive certain Covered Health Services from [¹Network or] non-Network providers, you are responsible for notifying us before you receive these services.

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.

Include when group purchases benefits for clinical trials.

- [Clinical trials.]

Include when group purchases benefits for congenital heart disease surgery.

- [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 does not purchase benefits for durable medical equipment.¹ Include if notification applies only to insulin pumps that exceed a specific dollar amount and insert appropriate dollar amount.

- [Diabetes equipment - insulin pumps [¹over \$[1,000 - 5,000]].]

Include when group purchases benefits for DME. ¹Include if notification applies only to DME that exceeds a specific dollar amount and insert appropriate dollar amount.

- [Durable Medical Equipment [¹over \$[1,000 - 5,000]].]

Include when notification is required for home health care.

- [Home health care.]

Include when notification is required for hospice care.

- [Hospice care - inpatient.]

¹Include when full maternity benefits are sold. ²Include when complications of pregnancy benefits are sold.

- Hospital inpatient care - all scheduled admissions [¹and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery] [²and stays for Complications of Pregnancy exceeding 96 hours for a cesarean section delivery].

Include when group purchases benefits for infertility services.

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

Include when notification is required for Lab/X-ray.

- [Lab, X-ray and diagnostics - sleep studies.]

Include when notification is required for Lab/X-ray-Major Diagnostics.

- [Lab, X-ray and major diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine.]

Include when group purchases benefits for obesity surgery.

- [Obesity surgery.]

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

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

Include when group purchases benefits for musculoskeletal disorders.

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

Include when notification is required for IV infusions.

- [Pharmaceutical Products - IV infusions only.]

Include when notification is required for select Pharmaceutical Products.

- [Certain Pharmaceutical Products. You may determine whether a particular Pharmaceutical Product requires notification through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

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

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

¹Include when group purchases benefits for breast reduction surgery.

- Reconstructive procedures [¹, including breast reduction surgery].

Include when group purchases benefits for rehabilitation services and when notification is required for any service. ¹Include when Manipulative Treatment is included in the rehabilitation services benefit.

- [Rehabilitation services [¹and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [¹Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [vision therapy].]

Include when notification is required for scopic procedures.

- [Scopic procedures - outpatient diagnostic and therapeutic.]
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.

Include when notification is required for outpatient surgeries.

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators]].]

Include when group purchases benefits for TMJ services and notification is required.

- [Temporomandibular joint services.]

Include when notification is required for outpatient therapeutics.

- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] hyperbaric oxygen therapy].]
- 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.]

¹*Include when Network providers are responsible for notification for Network Benefits.*

For all other services, [¹when you choose to receive services from [non-Network providers,] we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

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. ^{1-A}Include 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 this *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.]

¹Include here and in the header for the *Schedule of Benefits* table if the plan design provides Designated Network Benefits in any benefit category.

When Benefit limits apply, the limit stated refers to any combination of [¹Designated Network Benefits,] Network Benefits and Non-Network 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>¹Include when the Annual Deductible applies only to Non-Network Benefits.</p> <p>²Include when an Outpatient Prescription Drug Rider is sold and the Annual Deductible applies to any combination of medical and RX benefits.</p> <p>³Include when an Outpatient Prescription Drug Rider with separate Copayments for preventive medications is sold and the Annual Deductible does not apply to preventive medications.</p> <p>⁴Include 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.</p> <p>⁵Include when there is a deductible for Designated and Network Benefits and the network and non-network amounts apply to the Designated Network and Network Annual Deductible.</p> <p>⁶Include bracketed Designated Network reference when Designated Network Benefits apply to any category.</p>	<p>¹Include separate Network and Non-Network headings and statements when Annual Deductible provision applies separately to Network and Non-Network Benefits and delete the combined "Network and Non-Network" provision below.</p> <p>²Include when Designated Network Benefits apply to any category.</p>
<p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive [¹Non-Network] Benefits. [²The 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>. [³Benefits for Outpatient Prescription Drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.] [⁴Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the Outpatient Prescription Drug Rider are not subject to payment of the Annual Deductible.] [⁵The Annual Deductible for [⁶Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the <i>Outpatient Prescription Drug Rider</i>.]</p>	<p>[¹ ² Designated Network and] Network]</p> <p>Include when separate individual and family deductibles apply (non-embedded).</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>Include when day/visit limits are reduced by the number of days/visit used toward meeting the deductible.</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>Include when individual deductible applies (embedded).</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>Include when individual (with family maximum) deductible applies (embedded).</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</p> <p>Include when there is no annual deductible for network benefits.</p> <p>[No Annual Deductible.]</p> <p>[¹ Non-Network]</p> <p>Include when separate individual and family deductibles apply (non-</p>

<p><i>Include when dollar limits are reduced by the amount used toward meeting the deductible.</i></p>	<p><i>embedded).</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>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p>
<p><i>Include when the carry-over provision applies.</i></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>[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 when individual deductible applies (embedded).</i></p>
<p><i>Include paragraph if the roll-over provision applies to a group in any circumstance.</i></p>	<p>[\$[0 - 15,000] per Covered Person.]</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 when individual (with family maximum) deductible applies (embedded).</i></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>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</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><i>Include when there is no annual deductible for network benefits.</i></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>[No Annual Deductible.]</p>
<p><i>Include only when a per occurrence deductible applies.</i></p>	<p>¹<i>Include the combined Network and Non-Network heading and statements when Annual Deductible provision applies separately to combined Network and Non-Network Benefits and delete the separate "Network" and "Non-Network" provisions above.</i></p>
<p>[The Annual Deductible does not include any applicable Per Occurrence Deductible.]</p>	<p>²<i>Include when Designated Network Benefits apply to any category.</i></p>
	<p>[¹ ² Designated Network,] Network and Non-Network]</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</p>

	<p>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 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> <ul style="list-style-type: none"> • The applicable Per Occurrence Deductible. • The Eligible Expense.] 	<p>¹<i>Include when Designated Network Benefits apply to either category.</i></p> <p>[¹ Designated Network and] Network]</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 - 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>[Non-Network]</p> <p><i>Include when a per occurrence deductible applies to CHD surgery</i></p>

	<p><i>benefits.</i></p> <p>[CHD surgery - Inpatient Stay: [\$100 - 1,000] per day.]</p> <p>[CHD surgery - Inpatient Stay: [\$100 - 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: [\$50 - 800] 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>
Out-of-Pocket Maximum	

¹Include when OOPM includes the Annual Deductible.

²Include when OOPM includes the Per Occurrence Deductible.

³Include when OOPM includes Copayments.

⁴Include when an Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.

⁵Include when there is an OOPM for Designated and Network Benefit and the network and non-network amounts paid under the RX rider apply to the Designated Network and Network OOPM.

⁶Include bracketed Designated Network reference when Designated Network Benefits apply to any category.

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*.] [⁵The Out-of-Pocket Maximum for [⁶Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the *Outpatient Prescription Drug Rider*.]

⁷Include only when the plan design does not apply all Copayments/Coinsurance to the OOPM.

[⁷Copayments 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.

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:

- Any charges for non-Covered Health Services.

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.

- [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.

Include bullet when an Outpatient Prescription Drug Rider is

¹Include separate Network and Non-Network headings and statements when OOPM provision applies separately to Network and Non-Network Benefits and delete the combined "Network and Non-Network" provision below.

²Include when Designated Network Benefits apply to any category.

[¹ [² **Designated Network and** Network]

Include when separate individual and family maximums apply (non-embedded).

[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.

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].]

Include when individual OOPM applies (embedded).

[\$[0 - 45,000] per Covered Person.]

Include when individual (with family maximum) applies (embedded).

[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]

Include when the OOPM includes the Annual Deductible.

[The Out-of-Pocket Maximum includes the Annual Deductible.]

Include when the OOPM does not include the Annual Deductible.

[The Out-of-Pocket Maximum does not include the Annual Deductible.]

Include when the OOPM includes the Per Occurrence Deductible.

[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]

Include when the OOPM does not include the Per Occurrence Deductible.

[The Out-of-Pocket Maximum does not

<p><i>sold and Copayments/Coinsurance do not apply to the overall OOPM.</i></p>	<p>include the Per Occurrence Deductible.]</p>
<ul style="list-style-type: none"> • [Copayments or Coinsurance for Covered Health Services provided under the <i>Outpatient Prescription Drug Rider.</i>] 	<p><i>Include when there is no OOPM.</i></p> <p>[No Out-of-Pocket Maximum.]</p> <p>[¹ Non-Network]</p> <p><i>Include when separate individual and family maximums apply (non-embedded).</i></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><i>Include when individual OOPM applies (embedded).</i></p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p><i>Include when individual (with family maximum) applies (embedded).</i></p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p><i>Include when the OOPM includes the Annual Deductible.</i></p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p><i>Include when the OOPM does not include the Annual Deductible.</i></p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p><i>Include when the OOPM includes the Per Occurrence Deductible.</i></p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p><i>Include when the OOPM does not include the Per Occurrence Deductible.</i></p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p> <p><i>Include when there is no OOPM.</i></p> <p>[No Out-of-Pocket Maximum.]</p> <p>³<i>Include combined Network and Non-Network heading and statements below</i></p>

	<p><i>when OOPM provision applies to combined Network and Non-Network Benefits and delete the separate "Network" and "Non-Network" provisions above.</i></p> <p><i>²Include when Designated Network Benefits apply to any category.</i></p> <p><i>[³[Designated Network,] Network and Non-Network]</i></p> <p><i>Include when separate individual and family maximums apply (non-embedded).</i></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><i>Include when individual OOPM applies (embedded).</i></p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p><i>Include when individual (with family maximum) applies (embedded).</i></p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p><i>Include when the OOPM includes the Annual Deductible.</i></p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p><i>Include when the OOPM does not include the Annual Deductible.</i></p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p><i>Include when the OOPM includes the Per Occurrence Deductible.</i></p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p><i>Include when the OOPM does not include the Per Occurrence Deductible.</i></p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p>
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	<p><i>Include when there is no OOPM.</i></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<i>Include when separate Network and Non-Network Maximums apply.</i></p> <p>²<i>Include when Designated Network Benefits apply to any category.</i></p> <p>[¹ ² Designated Network and Network]</p> <p>[\$[1,000,000 - 10,000,000] per Covered Person.]</p> <p>[No Maximum Policy Benefit.]</p> <p>[¹ Non-Network]</p> <p>[\$[1,000,000 - 10,000,000] per Covered Person.]</p> <p>[No Maximum Policy Benefit.]</p> <p>³<i>Include when combined Network and Non-Network Maximums applies.</i></p> <p>[³ ² Designated Network,] Network and Non-Network]</p> <p>[\$[1,000,000 - 10,000,000] per Covered Person.]</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>¹ <i>Include when separate Network and Non-Network Maximums apply.</i></p> <p>² <i>Include when Designated Network Benefits apply to any category.</i></p> <p>[¹ [² Designated Network and] Network]</p> <p>[\$[2,000 - 500,000] per Covered Person.]</p> <p>[¹ Non-Network]</p> <p>[\$[2,000 - 500,000] per Covered Person.]</p> <p>³ <i>Include when combined Network and Non-Network Maximums applies.</i></p> <p>[³ [² Designated Network,] Network and Non-Network]</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.*

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

³Include 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.

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

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

³Include 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 refers to any combination of *[Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.*

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>[This limit applies to Network Benefits only. Non-Network Benefits are not available.]</p>	<p>[Network]</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>[Non-Network]</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>[Non-Network Benefits are not available.]</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>[Non-Network Benefits are not available.]</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>[Non-Network Benefits are not available.]</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>Network</p>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>[Ground ambulance limited to \$[500 - 5,000] per year.]</p>	<p>Ground Ambulance:</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>[Yes] [No]</p>	<p>[Yes] [No]</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>Air Ambulance:</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>Non-Network</p> <p>Same as Network</p>	<p>[Yes] [No]</p> <p>Same as Network</p>	<p>[Yes] [No]</p> <p>Same as Network</p>
<p>Non-Emergency Ambulance</p> <p>Ground or air ambulance, as we determine appropriate.</p>	<p>Network</p> <p>Ground Ambulance:</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 -</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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>Non-Network</p> <p>Same as Network</p>	<p>[Yes] [No]</p> <p>Same as Network</p>	<p>[Yes] [No]</p> <p>Same as Network</p>
<p><i>Include for groups that purchase benefits for clinical trials.</i></p> <p>[3.] [Clinical Trials]</p>			
<p><i>When Clinical Trials benefit is included, pre-service notification requirement will always apply.</i></p> <p>[Pre-service Notification Requirement]</p> <p>[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.]</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>Benefits are available when the Covered Health Services are provided by either Network or non-Network</p>	<p>[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>[Non-Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each</p>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)]</p>	<p>Covered Health Service category in this <i>Schedule of Benefits.</i>]</p>		
<p><i>Include for groups that purchase benefits for congenital heart disease services.</i></p> <p>[4.] [Congenital Heart Disease Surgeries]</p>			
<p><i>Include if pre-service notification is required.</i></p> <p>¹<i>Include if Non-Network Benefits are sold and if use of a Designated Facility is required in order to receive Network Benefits.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[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.] [¹Non-Network Benefits will apply.]</p> <p><i>Include when notification is required.</i></p> <p>¹<i>Include when the Covered Person is responsible for notification for Network Benefits.</i></p> <p>²<i>Include applicable reduction in Benefits.</i></p> <p>[For [¹Network and] Non-Network Benefits you must notify us as soon as the possibility of a Congenital Heart Disease (CHD) surgery arises. If you don't notify us, Benefits will be reduced to [²50 - 95]% of Eligible Expenses].</p>			
<p><i>Include when Designated Network Benefits are available.</i></p> <p>[When performed at a Designated Facility as part of the evaluation and treatment of CHD, Covered Health Services include diagnostic services, cardiac catheterization and all non-surgical management of CHD.]</p> <p><i>Include when CHD benefits are sold and when both Network and Non-</i></p>	<p>[Designated 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]</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 refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>Network Benefits are available.</i></p> <p>[Network and Non-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 in order to receive Network Benefits.</i></p> <p>[For Network Benefits, CHD surgeries must be received at a Designated Facility.</p> <p>Non-Network Benefits include services provided at a Network facility that is not a Designated Network Facility and services provided at a non-Network facility.</p> <p>Non-Network Benefits under this section include only the 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 Network and Non-Network Benefits are limited and insert the limit selected by the group.</i></p> <p>[Network and Non-Network Benefits are limited to \$[30,000 - 250,000] per CHD surgery.]</p> <p><i>Include when Non-Network Benefits are limited and insert the limit selected</i></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>[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>[Non-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</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible is satisfied]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>by the group.</i></p> <p>[Non-Network Benefits 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><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>¹<i>Include applicable reduction in Benefits or no Benefits.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[For Network and Non-Network Benefits 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>[Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit]</p> <p>[Non-Network]</p> <p>[Same as Network]</p>	<p>[Yes] [No]</p> <p>[Same as Network]</p>	<p>[Yes] [No]</p> <p>[Same as Network]</p>
<p>[6.] Diabetes Services</p>			
<p>¹<i>Include when the Covered Person is responsible for notification for Network Benefits.</i></p> <p>²<i>Include when the durable medical equipment benefit is sold.</i></p> <p>³<i>Include when the durable medical equipment benefit is not sold.</i></p> <p>⁴<i>Include when notification applies only to equipment that exceeds a minimum dollar amount and insert applicable dollar amount.</i></p> <p>⁵<i>Include applicable reduction in Benefits or no Benefits.</i></p>			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>sold and the Outpatient Prescription Drug Rider is sold.</i></p> <p>⁶<i>Include when sold with a plan that has an annual deductible and select either "are" or "are not."</i></p> <p>⁷<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>⁵<i>For 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.]</i></p> <p><i>Benefits for diabetes supplies will be the same as those stated in the Outpatient Prescription Drug Rider.]</i></p> <p>⁸<i>Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold.</i></p> <p>⁹<i>Include when sold with a plan that has an annual deductible and select either "are" or "are not."</i></p> <p>¹⁰<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>⁸<i>For 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.]]</i></p> <p>Non-Network</p> <p>¹<i>Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.</i></p> <p>¹<i>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider.]</i></p> <p>²<i>Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold.</i></p> <p>³<i>Include when sold with a plan that has an annual deductible and select either "are" or "are not."</i></p> <p>⁴<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>²<i>For diabetes equipment, Benefits will be the same as those stated under Durable Medical Equipment.</i></p> <p><i>For diabetes supplies the Benefit is [50 - 100]% of Eligible</i></p>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>Expenses [³and Benefits [are] [are not] subject to payment of 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>		
<p><i>Include for groups that purchase benefits for DME.</i></p> <p>[7.] [Durable Medical Equipment]</p>			
<p>¹Include when the Covered Person is responsible for notification for Network Benefits.</p> <p>²Include when notification applies only to DME that exceeds a minimum dollar amount and insert applicable dollar amount.</p> <p>³Include applicable reduction in Benefits or no Benefits.</p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[For [¹Network and] Non-Network Benefits you must notify us before obtaining any Durable Medical Equipment [²that exceeds \$[1,000 - 5,000] in cost (either purchase price or cumulative rental of a single item)]. If you fail to notify us as required, [³Benefits will be reduced to [50 - 95]% of Eligible Expenses] [³you will be responsible for paying all charges and no Benefits will be paid].]</p>			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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><i>¹Include either option as standard plan design.</i></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 includes disposable supplies necessary for the effective use of covered Durable Medical Equipment.] • [[\$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>[Network]</p> <p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of *[Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.*

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>[Non-Network]</i> [[50 - 100]%	[Yes] [No]	[Yes] [No]
[8.] Emergency Health Services - Outpatient			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.</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</i> 	<p>Network</p> <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>[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 refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>Nuclear Medicine - Outpatient.]</i></p> <ul style="list-style-type: none"> • [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 [and Manipulative Treatment].]</i>] 	<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] 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>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 if plan design includes retrospective review of emergency services.</i></p> <p>[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> <p>Non-Network Same as Network</p>	Same as Network	Same as Network
[9.] [Hearing Aids]			
<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 \$[500 - 5,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[two-five] years].]</p>	<p>[Network] [[50 - 100]%</p> <p>[Non-Network] [[50 - 100]%</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>
[10.] Home Health Care			
<p><i>Include if pre-service notification is required.</i></p> <p>¹<i>Include when the Covered Person is responsible for notification for Network Benefits.</i></p> <p>²<i>Include applicable reduction in Benefits.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p>			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
for an Inpatient Stay in a hospice facility.]			
	Network [[50 - 100]%] [100% after you pay a Copayment of \$[5 - 100] per day]	[Yes] [No]	[Yes] [No]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of \$[5 - 100] per day]	[Yes] [No]	[Yes] [No]
[12.] Hospital - Inpatient Stay			
<i>Include when Benefit Activation Program is sold.</i>			
<i>¹Include applicable Benefit level.</i>			
[Benefit Activation Notification Requirement] [For Network Benefits for Covered Health Services for certain 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.]			
<i>¹Include when the Covered Person is responsible for notification for Network Benefits.</i>			
<i>²Include applicable Benefit level.</i>			
Pre-service Notification Requirement For [¹ Network and] Non-Network Benefits for a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to notify us as required, Benefits will be reduced to [² 50 - 95]% of Eligible Expenses.			
<i>Include if pre-admission notification is required.</i>			
[In addition, for [¹ Network and] Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
<i>¹Include heading and row when Designated Network Benefits apply.</i> <i>Include when enhanced benefits apply</i>	[¹ Designated Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No] [Yes, after the Per

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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 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>[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>[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>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</p>	<p>[Yes] [No]</p>	<p>Occurrence Deductible is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible is satisfied]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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>Non-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>
<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 style="text-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>¹Include heading and row when Designated Network Benefits apply.</p> <p><i>Include the limit selected by the group.</i></p> <p>¹Include when the maximum benefit is combined with infertility drugs under</p>	<p>[¹ Designated Network]</p> <p>[[50 - 100]%</p> <p>[Network]</p> <p>[[50 - 100]%</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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>[Non-Network]</p> <p>[[50 - 100]%</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>
<p>[14.] Lab, X-Ray and Diagnostics - Outpatient</p>			
<p><i>Include when pre-service notification is required for sleep studies.</i></p> <p>¹<i>Include when the Covered Person is responsible for notification for Network Benefits.</i></p> <p>²<i>Include applicable reduction in Benefits.</i></p> <p align="center">[Pre-service Notification Requirement]</p> <p>[For [¹Network and] Non-Network Benefits for sleep studies, you must notify us five business days before scheduled services are received. If you fail to notify us as required, Benefits will be reduced to [²50 - 95] % of Eligible Expenses.]</p>			
<p>¹<i>Include heading and 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>[Non-Network Benefits are 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>Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 - 100] per service] Non-Network [[50 - 100]%] [100% after you pay a Copayment of \$[5 - 100] per service]	[Yes] [No]	[Yes] [No]
[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
<p><i>Include when pre-service notification is required for CT, PET, MRI, MRA and nuclear medicine.</i></p> <p>¹<i>Include when the Covered Person is responsible for notification for Network Benefits.</i></p> <p>²<i>Include applicable reduction in Benefits.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[For ¹Network and] Non-Network Benefits you must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to ²50 - 95% of Eligible Expenses.]</p>			
<p>¹<i>Include heading and 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>[Non-Network Benefits are limited to \$[100 - 5,000] per year.]</p>	<p>¹Designated Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[25 - 500] per service]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[25 - 500] per service]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[25 - 500] per service]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 mental health benefits. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. Remove entire benefit if group purchases MH full parity.</i></p> <p>¹Include if group purchases SA benefits.</p> <p>[16.] Mental Health Services</p>			
<p><i>When this benefit is purchased, prior authorization will always be required.</i></p> <p>¹Include as standard when parity applies.</p> <p>²Include applicable reduction in Benefits.</p> <p>³Include as standard when parity does not apply.</p> <p align="center">[Prior Authorization Requirement]</p> <p align="center">[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>[Network]</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>
<p><i>Select from these limit options when limits apply only to Mental Health Services described in this section.</i></p>	<p><i>[Outpatient]</i></p> <p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>[Inpatient/Intermediate <i>Mental Health Services</i> 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>[Non-Network Benefits for Inpatient/Intermediate <i>Mental Health Services</i> are limited to [10 - 100] days per year.]</p> <p>[Non-Network Benefits for 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>[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>[Non-Network]</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>
<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</p>	<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</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>		
<p>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.</p>	<p>[Network]</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>[Non-Network]</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>			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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>[Network]</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>
<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>[Non-Network Benefits for Inpatient/Intermediate Neurobiological Disorders -Autism Spectrum Disorders</i></p>	<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 refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>are limited to [10 - 100] days per year.]</p> <p>[Non-Network Benefits for outpatient Neurobiological Disorders -Autism Spectrum Disorders are limited to [10 - 100] visits per year.]</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>[Benefits for any combination of Neurobiological Disorders - Autism Spectrum Disorders 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 Neurobiological Disorders - Autism Spectrum Disorders and Mental Health Services. [10 - 100] visits per year for outpatient Neurobiological Disorders - Autism Spectrum Disorders and Mental Health Services.] 	<p>[Non-Network]</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>
	<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>
<p>Note: When parity applies, these benefit statements must be used in</p>	<p>[Network]</p>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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>Neurobiological Services - Autism Spectrum 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>Neurobiological Services - Autism Spectrum 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>[Non-Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits for outpatient <i>Neurobiological Services - Autism Spectrum 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>Neurobiological Services - Autism Spectrum 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><i>Include for groups that purchase benefits for obesity surgery.</i></p> <p>[18.] [Obesity Surgery]</p>			
<p><i>When this benefit is purchased, pre-service notification will always be required. ¹Include applicable Benefit level.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[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 [150 - 95]% of Eligible Expenses.]</p> <p><i>Include if pre-admission notification is required.</i></p> <p>¹<i>Include when the Covered Person is responsible for notification for Network Benefits.</i></p> <p>[In addition, for [¹Network and] Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.]</p>			

When Benefit limits apply, the limit refers to any combination of *[Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.*

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>[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.]</p>			
<p>¹Include heading and row when Designated Network Benefits apply.</p> <p>²Include when Designated Network Benefits apply.</p> <p>³Include when Network Benefits are available.</p> <p>⁴Insert the limit selected by the group.</p> <p>[Any combination of [²Designated Network Benefits] [³, Network Benefits] and Non-Network Benefits is limited to \$[⁴50,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy. Non-Network Benefits are further limited to \$[⁴5,000 - 30,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]</p> <p><i>Include when there is not a Network level of benefits available.</i></p> <p>[Non-Network Benefits include services provided at a Network facility that is not a Designated Network Facility and services provided at a non-Network facility.]</p>	<p><i>[¹ Designated Network]</i></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><i>[Network]</i></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><i>[Non-Network]</i></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><i>Include if group purchases benefits for ostomy supplies.</i></p> <p>[19.] [Ostomy Supplies]</p>			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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> [Limited to \$[500 - 25,000] per year.]</p>	<p>[Network] [[50 - 100]%]</p> <p>[Non-Network] [[50 - 100]%]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>
<p>[20.] Pharmaceutical Products - Outpatient</p>			
<p><i>Include when notification is required for IV infusions.</i></p> <p>¹<i>Include when the Covered Person is responsible for notification for Network Benefits.</i></p> <p>²<i>Include applicable reduction in Benefits.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[For [¹Network and] Non-Network Benefits you must notify us five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [²50 - 95]% of Eligible Expenses.]</p> <p><i>Include when notification is required for select Pharmaceutical Products.</i></p> <p>[For [¹Network and] Non-Network Benefits you must notify us five business days before certain pharmaceutical products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [²50 - 95]% of Eligible Expenses. You may determine whether a particular Pharmaceutical Product requires notification through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>			
<p>¹<i>Include heading and row when Designated Network Benefits apply.</i> <i>Include limit selected by group.</i> [Limited to \$[100 - 5,000] per year.] [Non-Network Benefits are limited to \$[100 - 5,000] per year.]</p>	<p>[¹ Designated Network] [[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]</p>	<p>[Yes] [No]</p> <p>[Yes, except when provided during a Physician office visit]</p>	<p>[Yes] [No]</p> <p>[Yes, except when provided during a Physician office visit]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>[[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]</p> <p>Network</p> <p>[[50 - 100]%) [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>Non-Network</p> <p>[[50 - 100]%) [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>[Yes] [No]</p> <p>[Yes, except when provided during a Physician office visit]</p> <p>[Yes] [No]</p> <p>[Yes, except when provided during a Physician office visit]</p>	<p>[Yes] [No]</p> <p>[Yes, except when provided during a Physician office visit]</p> <p>[Yes] [No]</p> <p>[Yes, except when provided during a Physician office visit]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]		
[21.] Physician Fees for Surgical and Medical Services			
<i>Include when Benefit Activation Program is sold.</i>			
<i>¹Include applicable Benefit level.</i>			
<p>[Benefit Activation Notification Requirement]</p> <p>[For Network Benefits 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>¹Include heading and 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.] 	<p>[¹ Designated Network]</p> <p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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"> • [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 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 Customer Care at the telephone number on your ID card.]</p> <p>²Include text if the plan design supports paying non-network benefits for a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist).</p> <p>[²Covered Health Services provided by a non-Network facility-based Physician (a non-Network anesthesiologist,</p>	<p>Network</p> <p>[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>radiologist, or pathologist) in a Network facility will be paid as Non-Network Benefits.]</p> <p>³Include text if the plan design supports paying non-network benefits for a non-Network consulting Physician, assistant surgeon or surgical assistant.</p> <p>[³Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Non-Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.]</p>	<p>Non-Network</p> <p>[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<p>[22.] Physician's Office Services - Sickness and Injury</p>			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 Activation Program is sold.</i></p> <p>¹<i>Include applicable Benefit level.</i></p>			
<p>[Benefit Activation Notification Requirement]</p> <p>[For Network Benefits 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>¹<i>Include heading and row when Designated Network Benefits apply.</i></p> <p><i>Include when enhanced benefits apply to specific physician office 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.] 	<p>[¹ Designated 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</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 refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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"> • [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 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 specialties 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>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>		
<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</i></p>	<p>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]</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 refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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 - Outpatient.</i>] • [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>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> <p>Non-Network</p>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>[[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 - 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</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 refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[#] visits in a year; [50 - 90]% for any subsequent visits in that year]		
<p>¹Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude. ²If Maternity Services are excluded, Complications of Pregnancy must always be included.</p> <p>[23.] Pregnancy - [¹Maternity Services] [²Complications of Pregnancy only]</p>			
<p>¹Include when benefits are provided for maternity services. ²Include when the Covered Person is responsible for notification for Network Benefits. ³Include applicable Benefit level.</p>			
<p align="center">[¹Pre-service Notification Requirement]</p> <p align="center">[¹For [²Network and] Non-Network Benefits you must notify us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to notify us as required, Benefits will be reduced to [³50 - 95]% of Eligible Expenses.]</p>			
<p>⁴Include when benefits are provided for complications of pregnancy only. ⁵Include when the Covered Person is responsible for notification for Network Benefits. ⁶Include applicable Benefit level.</p>			
<p align="center">[⁴Pre-service Notification Requirement]</p> <p align="center">[⁴For [⁵Network and] Non-Network Benefits you must notify us five business days before admission for scheduled admissions or within one business day or the same day, or as soon as is reasonably possible for non-scheduled admissions. If you fail to notify us as required, Benefits will be reduced to [⁶50 - 95]% of Eligible Expenses.]</p> <p align="center">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. [¹ Network] ³Include when an annual deductible applies to network benefits.</p>			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>⁴Include when Network 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>[¹ Non-Network]</p> <p>³Include when an annual deductible applies to non-network benefits.</p> <p>⁴Include when Non-Network 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> <p>[² Network]</p> <p>[²Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p> <p>[² Non-Network]</p> <p>[²Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>		
[24.] Preventive Care Services			
<p><i>Include when preventive care is limited and select the limit that applies.</i></p> <p>[Preventive care services are limited to \$[100 - 1,000] per year.]</p> <p>Physician office services</p> <ul style="list-style-type: none"> Well baby and well child care includes, but is limited to, 20 	<p>Network</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]</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 refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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> <p>No Copayment, Coinsurance or deductible will be applicable to Network or non-Network children's immunizations.</p>	<p>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>Non-Network</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>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not available except for children under the age of 19.]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not available except for children under the age of 19.]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Lab, X-ray or other preventive tests:	<p>[Non-Network Benefits are not available.]</p> <p>Network</p> <p>[[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>Non-Network</p> <p>[[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[Non-Network Benefits are not available except for children under the age of 19.]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Non-Network Benefits are not available except for children under the age of 19.]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Non-Network Benefits are not available except for children under the age of 19.]</p>
<p>[25.] Prosthetic Devices and Services</p>			
<p><i>Include if notification is required.</i></p> <p>¹Include when the Covered Person is responsible for notification for Network Benefits.</p> <p>²Include when notification applies only to prosthetics that exceed a minimum dollar amount and insert applicable dollar amount.</p> <p>³Include applicable reduction in Benefits or no Benefits.</p> <p align="center">[Pre-service Notification Requirement]</p> <p>[For [¹Network and] Non-Network Benefits you must notify us before obtaining prosthetic devices [²that exceed \$[1,000 - 5,000] in cost per device]. If you fail to notify us as required, [³Benefits will be reduced to [50 - 95] % of Eligible Expenses] [³you 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 prosthetic device every three years.	<p>[Network]</p> <p>[[50 - 100] %]</p> <p>[Non-Network]</p> <p>[[50 - 100] %]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>
<p>[26.] Reconstructive Procedures</p>			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>¹Include when the Covered Person is responsible for notification for Network Benefits.</p>			
<p>²Include applicable Benefit level.</p>			
<p style="text-align: center;">Pre-service Notification Requirement</p> <p>For [¹Network and] Non-Network Benefits you must notify us five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [²50 - 95]% of Eligible Expenses.</p> <p><i>Include if pre-admission notification is required.</i></p> <p>[In addition, for [¹Network and] Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]</p>			
	<p>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><i>Include when group does not purchase benefits for prosthetic devices.</i></p> <p>¹Include when sold with a plan that has an annual deductible and select either "are" or "are not."</p> <p>²Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."</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>Non-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><i>Include when group does not purchase benefits for prosthetic devices. The Benefit level inserted here must be the same as the plan Coinsurance level.</i></p> <p>¹Include when sold with a plan that has an annual deductible and select either "are" or "are not."</p> <p>²Include when sold with a plan that has an out-of-pocket</p>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>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 notification is required for any rehabilitation service.</i></p> <p>¹<i>Include when the Covered Person is responsible for notification for Network Benefits.</i></p> <p>²<i>Include applicable Benefit level.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[For [¹Network and] Non-Network Benefits you must notify us five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [vision therapy] or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [²50 - 95]% of Eligible Expenses.]</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 Treatment.] • [10-100] visits of speech therapy. 	<p>[Network]</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>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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"> • [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, occupational therapy, [¹Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy,</p>	<p>[Non-Network]</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>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 rehabilitation therapy, post-cochlear implant aural therapy, [²and vision therapy] is limited to \$[750 - 12,000] per year.]</p> <p><i>Include when combined therapy visit limits apply separately to network benefits and to non-network benefits.</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>[Network Benefits for any combination of physical therapy, occupational therapy, [¹Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [²and vision therapy] are limited to [10 - 160] visits per year.]</p> <p>[Non-Network Benefits for 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] are limited to [10 - 160] visits per year.]</p>			
<p>[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic</p>			
<p><i>Include when notification is required for scopic procedures.</i></p> <p>¹<i>Include when the Covered Person is responsible for notification for Network Benefits.</i></p> <p>²<i>Include applicable Benefit level.</i></p>			
<p>[Pre-service Notification Requirement]</p>			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>[For [1Network and] Non-Network Benefits you must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [250 - 95]% of Eligible Expenses.]</p>			
<p>¹Include heading and row when Designated Network Benefits apply.</p>	<p>[1 Designated Network] [[50 - 100]% Network [50 - 100]% Non-Network [50 - 100]%</p>	<p>[Yes] [No] [Yes] [No] [Yes] [No]</p>	<p>[Yes] [No] [Yes] [No] [Yes] [No]</p>
<p>[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</p>			
<p>¹Include when the Covered Person is responsible for notification for Network Benefits. ²Include applicable Benefit level.</p> <p style="text-align: center;">Pre-service Notification Requirement</p> <p>For [1Network and] Non-Network Benefits for a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to notify us as required, Benefits will be reduced to [250 - 95]% of Eligible Expenses.</p> <p><i>Include if pre-admission notification is required.</i></p> <p>[In addition, for [1Network and] Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>			
<p><i>Include limit selected by group.</i> [Limited to [40 - 180] days per year.] [Network Benefits are limited to [40 - 180] days per year. Non-Network Benefits are limited to [40 - 180] days per year.]</p>	<p>Network [[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> [1100% after you pay a</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>Copayment of \$[50 - 2,000] per Inpatient Stay]</p> <p>[¹100% after you pay a Copayment of \$[50 - 1,000] per day to a maximum Copayment of \$[50 - 5,000] per Inpatient Stay]</p> <p><i>Variable #1 can be used only with options 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>Non-Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[50 - 1,000] per day]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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% after you pay a Copayment of \$[50 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[50 - 1,000] per day to a maximum Copayment of \$[50 - 10,000] per Inpatient Stay]</p>		
<p><i>Include for groups that purchase substance use disorder benefits. Include ONLY when group purchases plan with outpatient SA benefits with MH full parity or no MH. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing</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, 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</i></p>	<p>[Network]</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</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>statements and use the "Depending upon" provisions further below."</i></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><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>[Non-Network Benefits for Inpatient/Intermediate Substance Use Disorder Services are limited to [10 - 100] days per year.]</p> <p>[Non-Network Benefits for 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 	<p>[Outpatient]</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 refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>[Disorder Services.]</i></p>	<p>[Non-Network] <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]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
	<p><i>[Outpatient]</i> [[50 - 100] %] [100% after you pay a Copayment of \$[5 - 100] per visit] [100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.] [100% for visits for medication management]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<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>[Network] [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>.] <i>Include when outpatient visits for medication management are</i></p>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>paid at 100%.</i></p> <p>[Benefits for outpatient visits for medication management will be paid at 100%.]</p>		
	<p>[Non-Network]</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>		
[31.] Surgery - Outpatient			
<p><i>Include when Benefit Activation Program is sold.</i></p>			
<p>¹<i>Include applicable Benefit level.</i></p>			
<p align="center">[Benefit Activation Notification Requirement]</p>			
<p>[For Network Benefits 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><i>Include when notification is required.</i></p>			
<p>¹<i>Include when the Covered Person is responsible for notification for Network Benefits.</i></p>			
<p>²<i>Include applicable Benefit level.</i></p>			
<p align="center">[Pre-service Notification Requirement]</p>			
<p>[For [¹Network and] Non-Network Benefits [for all outpatient surgeries] [for [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators]] you must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [²50 - 95]% of Eligible Expenses.]</p>			
<p>¹<i>Include heading and row when Designated Network Benefits apply.</i></p>	<p>[¹ Designated Network]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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 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 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>[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>[[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>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 -</p>	<p>[Yes] [No]</p>	<p>[Yes, after the Per Occurrence Deductible is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible is satisfied]</p>

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year]]</p> <p>Non-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. This is a mandated benefit in Arkansas.</i></p> <p>[32.] [Temporomandibular Joint Services]</p>			
<p><i>When this benefit is purchased, pre-service notification will always be required.</i></p> <p>¹<i>Include when the Covered Person is responsible for notification for Network Benefits.</i></p> <p>²<i>Include applicable Benefit level.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p style="text-align: center;">[For [¹Network and] Non-Network Benefits you must notify us five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to notify us as required, Benefits will be reduced to [²50 - 95]% of Eligible Expenses.]</p> <p><i>Include if pre-admission notification is required.</i></p> <p>[In addition, for [¹Network and] Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions.]</p>			
<p><i>Include the limit selected by the group.</i></p> <p>[Limited to \$[1,000 - 20,000] per year.]</p>	<p>[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>[Non-Network]</p>		

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.]			
[33.] Therapeutic Treatments - Outpatient			
<i>Include when notification is required.</i>			
¹ <i>Include when the Covered Person is responsible for notification for Network Benefits.</i>			
² <i>Include applicable Benefit level.</i>			
<p align="center">[Pre-service Notification Requirement]</p> <p>[For [¹Network and] Non-Network Benefits you must notify us [for all outpatient therapeutic services] [for the following outpatient therapeutic services] five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [Services that require notification: [dialysis] [,] [and] chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [hyperbaric oxygen therapy].] If you fail to notify us as required, Benefits will be reduced to [²50 - 95] % of Eligible Expenses.]</p>			
¹ <i>Include heading and row when Designated Network Benefits apply.</i>	<p>¹ Designated Network</p> <p>[[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment]</p> <p>Network</p> <p>[[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment]</p> <p>Non-Network</p> <p>[[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>
[34.] Transplantation Services			
<p align="center">Pre-service Notification Requirement</p>			
<p>For Network Benefits 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</p>			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	maximum Copayment of \$[100 - 5,000] per Inpatient Stay]		
[35.] Urgent Care Center Services			
<p><i>Include when urgent care services are limited and insert the limit selected by the group.</i></p> <p>[Limited to \$[100 - 5,000] per year.] [Limited to [2 - 10] visits per year.]</p> <p><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 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 	<p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit to a maximum Copayment of \$[5 - 5,000] per year]</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 - 150] 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 refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>described under <i>Surgery - 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>Non-Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit to a maximum Copayment of \$[5 - 5,000] per year]</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 - 150] 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><i>Include when group purchases benefits for vision exams.</i></p>			

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>Benefits will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>. Non-Network Benefits will be the same as those stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>.</p>		
[39.] In Vitro Fertilization Services			
<p>¹<i>Include applicable Benefit level.</i></p> <p style="text-align: center;">Pre-service Notification Requirement</p> <p>You must notify us as soon as the possibility of the need for in vitro fertilization arises. If you fail to notify us as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.</p>			
<p>¹<i>Include heading and row when Designated Network Benefits apply</i></p> <p>Limited to a lifetime maximum of \$15,000.</p>	<p>¹[Designated Network] [50 - 100%]</p> <p>Network [50 - 100%]</p> <p>Non-Network [[50 - 100]%%] [Non-Network Benefits are not available.]</p>	<p>¹<i>Include heading and row when Designated Network Benefits apply</i></p> <p>Limited to a lifetime maximum of \$15,000.</p>	<p>¹[Designated Network] [50 - 100%]</p> <p>Network [50 - 100%]</p> <p>Non-Network [[50 - 100]%%] [Non-Network Benefits are not available.]</p>
[40.] Medical Foods			
	<p>¹<i>Include when group purchases the Outpatient Prescription Drug Rider.</i></p> <p>Network Depending upon where the Covered Health Service is provided, Benefits will be [50 - 100]% ¹or as provided under the <i>Outpatient Prescription</i></p>	[Yes] [No]	[Yes] [No]

When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.

The maximum differential between network and non-network benefit levels is 25% per Arkansas law.

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>Drug Rider</i> . Non-Network Same as Network	Same as Network	Same as Network
<i>Mandated offer in Arkansas.</i>			
[[41.] Musculoskeletal Disorders of the Face, Neck or Head]			
[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> .]	[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> .]		
[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> .]	[Non-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> .]		
[42.] Orthotic Devices and Services			
Include if notification is required. ¹ Include when notification applies only to orthotics that exceed a minimum dollar amount and insert applicable dollar amount. ² Include applicable reduction in Benefits or no Benefits.			
[Pre-service Notification Requirement] [For Non-Network Benefits you must notify us before obtaining orthotic devices [¹ that exceed \$[1,000 - 5,000] in cost per device]. If you fail to notify us as required, [² Benefits will be reduced to [50 - 95]% of Eligible Expenses] [² you will be responsible for paying all charges and no Benefits will be paid].			
Benefits for replacements are limited to a single purchase of each type of orthotic device every three years.	Network [50 - 100%] Non-Network [50 - 100%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

Eligible Expenses

¹*Include when Designated Network Benefits apply for any Covered Health Service.*

Eligible Expenses are the amount we determine that we will pay for Benefits. For [¹Designated Network Benefits and] Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. 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.

¹*Include when group purchases MH benefits.* ²*Include 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.]

For [¹Designated Network Benefits and] Network Benefits, Eligible Expenses are based on either of the following:

- 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 state law].

For Non-Network Benefits, Eligible Expenses are based on either of the following:

Include the provisions that apply for determining Eligible Expenses for Non-Network Benefits.

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, [at our discretion,] based on [the lesser of]:

¹*When using PHCS to determine Eligible Expenses for Non-Network Benefits, include the following and delete MNRP provisions.*

- [¹For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
- When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [____]% of the amount that the *Centers for Medicare and Medicaid Services (CMS)* would have paid under the Medicare program for the drug determined by either of the following:
 - ◆ Reference to available CMS schedules.
 - ◆ Methods similar to those used by CMS.
- Fee(s) that are negotiated with the provider.
- [50 - 100]% of the billed charge.
- A fee schedule that we develop.]

²When using MGRP to determine Eligible Expenses for Non-Network Benefits, include the following and delete PHCS provisions.

- [²Fee(s) that are negotiated with the provider.
 - [_____] % of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service [within the geographic market].
 - [50 - 100] % of the billed charge.
 - A fee schedule that we develop.]
- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

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.

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.

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 us 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.

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, Network 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, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

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, Covered Health Services will be paid as Non-Network Benefits.

UnitedHealthcare [Non-Differential PPO]

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider regardless of their Network status. This Benefit plan does not provide a Network Benefit level or a Non-Network Benefit level.

We arrange for health care providers to participate in a Network. Depending on the geographic area, you may have access to Network providers. These providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from a Network provider, your Coinsurance level will remain the same. However, the portion that you owe may be less than if you received services from a non-Network provider because the Eligible Expense may be a lesser amount.

¹Always include unless the Shared Savings Program does not apply to Benefits under this COC. "Shared Savings Program" is bracketed to accommodate possible name change.

Depending on the geographic area and the service you receive, you may have access [¹through our [Shared Savings Program]] to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less [¹when you receive Covered Health Services from [Shared Savings Program] providers than from other non-Network providers] because the Eligible Expense may be a lesser amount.

You should show your identification card (ID card) every time you request health care services so that the provider knows that you are enrolled under a [UnitedHealthcare] Policy.

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 notification provisions below when Pre-service Benefit Confirmation is required for any benefit category.

[Pre-service Benefit Confirmation]

[We require notification before you receive certain Covered Health Services. 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.

Include when group purchases benefits for clinical trials.

- [Clinical trials.]

Include when group purchases benefits for congenital heart disease surgery.

- [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 does not purchase benefits for durable medical equipment.¹ Include if notification applies only to insulin pumps that exceed a specific dollar amount and insert appropriate dollar amount.

- [Diabetes equipment - insulin pumps [¹over \$[1,000 - 5,000]].]

Include when group purchases benefits for DME.¹ Include if notification applies only to DME that exceeds a specific dollar amount and insert appropriate dollar amount.

- [Durable Medical Equipment [¹over \$[1,000 - 5,000]].]

Include when notification is required for home health care.

- [Home health care.]

Include when notification is required for hospice care.

- [Hospice care - inpatient.]

¹Include when full maternity benefits are sold. ²Include when complications of pregnancy benefits are sold.

- Hospital inpatient care - all scheduled admissions [¹and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery] [²and stays for Complications of Pregnancy exceeding 96 hours for a cesarean section delivery].

Include when group purchases benefits for infertility services.

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

Include when notification is required for Lab/X-ray.

- [Lab, X-ray and diagnostics - sleep studies.]

Include when notification is required for Lab/X-ray-Major Diagnostics.

- [Lab, X-ray and major diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine.]

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]].**

Include when group purchases benefits for musculoskeletal disorders.

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

Include when notification is required for IV infusions.

- [Pharmaceutical Products - IV infusions only.]

Include when notification is required for select Pharmaceutical Products.

- [Certain Pharmaceutical Products. You may determine whether a particular Pharmaceutical Product requires notification through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

Include when group purchases benefits for prosthetics. ¹Include if notification applies only to prosthetics that exceed a specific dollar amount and insert appropriate dollar amount.

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

¹Include when group purchases benefits for breast reduction surgery.

- [Reconstructive procedures [¹, including breast reduction surgery].]

Include when group purchases benefits for rehabilitation services and when notification is required for any service. ¹Include when Manipulative Treatment is included in the rehabilitation services benefit.

- [Rehabilitation services [¹and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [¹Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [vision therapy].]

Include when notification is required for scopic procedures.

- [Scopic procedures - outpatient diagnostic and therapeutic.]
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.

Include when notification is required for outpatient surgeries.

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators]].]

Include when group purchases benefits for TMJ services and notification is required.

- [Temporomandibular joint services.]

Include when notification is required for outpatient therapeutics.

- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] hyperbaric oxygen therapy].]
- Transplants.]

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

¹Include if Mental Health Benefits are sold.

²Include 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.]

Include two paragraphs below when notification is required.

[For all other services, we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

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. ^{1-A}Include 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 this *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.]

Always include Care Coordination provision except when notification is not required for any service.

[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.]

Always include "Special Note Regarding Medicare" provision except when notification is not required for any service.

[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.]

Always include except when limits do not apply for any service.

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

Payment Term And Description	Amounts
Annual Deductible	
<p>¹Include when an Outpatient Prescription Drug Rider is sold and the Annual Deductible applies to any combination of medical and RX benefits.</p> <p>²Include when an Outpatient Prescription Drug Rider with separate Copayments for preventive medications is sold and the Annual Deductible does not apply to preventive medications.</p> <p>³Include 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.</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</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 <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.]</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 <i>Schedule of Benefits</i> 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 <i>Schedule of Benefits</i> 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 <i>Schedule of Benefits</i> 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 <i>Outpatient Prescription Drug Rider</i>.] 	<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 is not subject to benefit limits in any category.

[This Benefit plan does not apply dollar, visit or day limits to any of the Covered Health Services described below in the *Schedule of Benefits* table.]

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.]

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>	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
<p>[2.] Ambulance Services</p>			
<p><i>Always include Pre-service Notification Requirement except when notification is not required for any service.</i></p> <p style="text-align: center;">[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>Non-Emergency Ambulance</p> <p>Ground or air ambulance, as we determine appropriate.</p>	<p><i>Ground Ambulance:</i></p> <p>[50 - 100]%</p> <p><i>Air Ambulance:</i></p> <p>[50 - 100]%</p> <p><i>Ground Ambulance:</i></p> <p>[50 - 100]%</p> <p><i>Air Ambulance:</i></p> <p>[50 - 100]%</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</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>			
<p><i>Always include Pre-service Notification Requirement except when notification is not required for any service.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[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> .	[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 when notification is required.</i> ¹ <i>Include applicable reduction in Benefits.</i> [You must notify us as soon as the possibility of a Congenital Heart Disease (CHD) surgery arises. If you don't notify us, Benefits will be reduced to [150 - 95]% of Eligible Expenses].			
<i>Include when Benefits are limited and insert the limit selected by the group.</i> [Limited to \$[30,000 - 250,000] per Congenital Heart Disease (CHD) surgery.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
<i>Include for groups that purchase benefits for accident-related dental services.</i> [5.] [Dental Services - Accident Only]			
<i>Include when pre-service notification is required.</i> ¹ <i>Include applicable reduction in Benefits or no Benefits.</i> [Pre-service Notification Requirement] [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, [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].]			
[Limited to \$[2,000 - 5,000] per year. Benefits are further limited to a maximum of \$[500 - 1,500] per tooth.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[6.] Diabetes Services			
<i>Always include Pre-service Notification Requirement except when notification is not required for any service.</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>¹Include when the durable medical equipment benefit is sold.</p> <p>²Include when the durable medical equipment benefit is not sold.</p> <p>³Include when notification applies only to equipment that exceeds a minimum dollar amount and insert applicable dollar amount.</p> <p>⁴Include applicable reduction in Benefits or no Benefits.</p>			
<p align="center">[Pre-service Notification Requirement]</p> <p>[You must notify us before obtaining any [¹Durable Medical Equipment] [²diabetes equipment] for the management and treatment of diabetes [³that exceeds \$[1,000 - 5,000] in cost (either purchase price or cumulative rental of a single item)]. If you fail to notify us as required, [⁴Benefits will be reduced to [50 - 95]% of Eligible Expenses] [⁴you will be responsible for paying all charges and no Benefits will be paid].]</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>Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.</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>¹Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.</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>²Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold.</p> <p>³Include when sold with a plan that has an annual deductible and select either "are" or "are not."</p> <p>⁴Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."</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 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</p>		

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>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 <i>Outpatient Prescription Drug Rider</i> 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>		
<p>Include for groups that purchase benefits for DME.</p> <p>[7.] [Durable Medical Equipment]</p>			
<p>Always include <i>Pre-service Notification Requirement</i> except when notification is not required for any service.</p> <p>¹Include when notification applies only to DME that exceeds a minimum dollar amount and insert applicable dollar amount.</p> <p>²Include applicable reduction in Benefits or no Benefits.</p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[You must notify us before obtaining any Durable Medical Equipment [¹that exceeds \$[1,000 - 5,000] in cost (either purchase price or cumulative rental of a single item)]. 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>			
<p>Include the limit selected by the group.</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 includes disposable supplies necessary for the effective use of covered Durable Medical 	<p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>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>¹Include when Benefits are provided for speech aid and tracheo-esophageal voice devices.</p> <p>²Include when devices are not included in the annual DME limit.</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>			
[8.] Emergency Health Services - Outpatient			
<p>Include when benefit is limited.</p> <p>[Limited to \$[100 - 5,000] per year.]</p>	[50 - 100]%	[Yes] [No]	[Yes] [No]
<p>Include as standard only for groups of 15+.</p> <p>[9.] [Hearing Aids]</p>			
<p>Include the limit selected by the group.</p> <p>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.</p> <p>[Limited to \$[500 - 5,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[two-</p>	[[50 - 100]%]	[Yes] [No]	[Yes] [No]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
five] years].]			
[10.] Home Health Care			
<i>Include if pre-service notification is required.</i>			
¹ <i>Include applicable reduction in Benefits.</i>			
[Pre-service Notification Requirement]			
[You must notify us five business days before receiving services or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [¹ 50 - 95]% of Eligible Expenses.]			
<i>Include the limit selected by the group.</i> [Limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.] [Limited to \$[500 - 5,000] per year.] [Limited to [40 - 200] visits per year to a maximum of \$[500 - 5,000] in Eligible Expenses per year.] <i>Include when infusion administration only is not included in the limit.</i> [This visit limit does not include any service which is billed only for the administration of intravenous infusion.]	[50 - 100]%	[Yes] [No]	[Yes] [No]
[11.] Hospice Care			
<i>Include if pre-service notification is required.</i>			
¹ <i>Include applicable reduction in Benefits.</i>			
[Pre-service Notification Requirement]			
[You must notify us five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [¹ 50 - 95]% of Eligible Expenses.]			
<i>Include if pre-admission notification is required.</i>			
[In addition, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]			
	[50 - 100]%	[Yes] [No]	[Yes] [No]
[12.] Hospital - Inpatient Stay			
<i>Always include Pre-service Notification Requirement except when notification is not required for any service.</i>			
¹ <i>Include applicable Benefit level.</i>			
[Pre-service Notification Requirement]			
[For a scheduled admission, you must notify us five business days before admission, or as soon as is			

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>reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to notify us as required, Benefits will be reduced to [150 - 95]% of Eligible Expenses.]</p> <p><i>Include if pre-admission notification is required.</i></p> <p>[In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>			
	[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
<p><i>Include for groups that purchase infertility benefits.</i></p> <p>[13]. [Infertility Services]</p>			
<p><i>Always include Pre-service Notification Requirement except when notification is not required for any service.</i></p> <p>¹<i>Include applicable reduction in Benefits or no Benefits.</i></p> <p style="text-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, [Benefits 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>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>	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
<p>[14.] Lab, X-Ray and Diagnostics - Outpatient</p>			
<p><i>Include when pre-service notification is required for sleep studies.</i></p> <p>¹<i>Include applicable reduction in Benefits.</i></p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[Pre-service Notification Requirement] [For sleep studies, you must notify us five business days before scheduled services are received. If you fail to notify us as required, Benefits will be reduced to [150 - 95]% of Eligible Expenses.]			
<i>Include limit selected by group.</i> [Limited to \$[100 - 5,000] per year.]	[50 - 100]%	[Yes] [No]	[Yes] [No]
[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
<i>Include when pre-service notification is required for CT, PET, MRI, MRA and nuclear medicine.</i> ¹ Include applicable reduction in Benefits.			
[Pre-service Notification Requirement] [You must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [150 - 95]% of Eligible Expenses.]			
<i>Include limit selected by group.</i> [Limited to \$[100 - 5,000] per year.]	[50 - 100]%	[Yes] [No]	[Yes] [No]
<i>Include for groups that purchase Mental Health benefits. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. Remove entire benefit if group purchases MH full parity.</i> ¹ Include if group purchases SA benefits.			
[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: 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	<i>[Inpatient/Intermediate]</i> [[50 - 100]%]	[Yes] [No]	[Yes] [No]

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>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>Select from these limit options when limits apply only to Mental Health Services described in this section.</i></p> <p>[Inpatient/Intermediate Mental Health Services are limited to [10 - 100] days per year.]</p> <p>[Outpatient Mental Health Services 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 Mental Health Services described in this section and Neurobiological Disorders - Autism Spectrum Disorders described below are limited as follows:</p> <ul style="list-style-type: none"> • [10 - 100] days per year for Inpatient/Intermediate Mental Health Services and Neurobiological Disorders - Autism Spectrum Disorders. • [10 - 100] visits per year for outpatient Mental Health Services and Neurobiological Disorders - Autism Spectrum Disorders.] <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 Mental Health Services described in this section and Substance Use</p>	<p><i>[Outpatient]</i></p> <p><i>[[50 - 100]%</i></p>	<p><i>[Yes] [No]</i></p>	<p><i>[Yes] [No]</i></p>

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>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>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>[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>[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</i></p>	<p><i>[Inpatient/Intermediate]</i></p> <p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<i>limits can be used. When parity does apply, delete these benefit and limit statements and use the "Depending upon" provisions further below."</i>			
<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><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><i>[Outpatient]</i></p> <p><i>[[50 - 100]%</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>

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[Benefits for outpatient visits for medication management will be paid at 100%.]		
<p><i>Include for groups that purchase benefits for obesity surgery.</i></p> <p>[18.] [Obesity Surgery]</p>			
<p><i>Always include Pre-service Notification Requirement except when notification is not required for any service.</i></p> <p>¹<i>Include applicable Benefit level.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[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 [¹50 - 95]% of Eligible Expenses.]</p> <p><i>Include if pre-admission notification is required.</i></p> <p style="text-align: center;">[In addition, you must contact us 24 hours before admission for an Inpatient Stay.]</p> <p style="text-align: center;">[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.]</p>			
<p><i>Include when group chooses to limit benefit.</i></p> <p>¹<i>Insert the limit selected by the group.</i></p> <p>[Limited to \$[¹50,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]</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><i>Include if group purchases benefits for ostomy supplies.</i></p> <p>[19.] [Ostomy Supplies]</p>			
<p><i>Include the limit selected by the group.</i></p> <p>[Limited to \$[500 - 25,000] per year.]</p>	[[50 - 100]%	[Yes] [No]	[Yes] [No]
<p>[20.] Pharmaceutical Products - Outpatient</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Include when notification is required for IV infusions.</i></p> <p>¹<i>Include applicable reduction in Benefits.</i></p>			
<p>[Pre-service Notification Requirement]</p>			
<p>[You must notify us five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [150 - 95]% of Eligible Expenses.]</p>			
<p><i>Include when notification is required for select Pharmaceutical Products.</i></p>			
<p>[You must notify us five business days before certain pharmaceutical products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [150 - 95]% of Eligible Expenses. You may determine whether a particular Pharmaceutical Product requires notification through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>			
<p><i>Include limit selected by group.</i></p> <p>[Limited to \$[100 - 5,000] per year.]</p>	<p>[[50 - 100]%]</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]</p> <p>[[50 - 100]% - Tier 2]</p> <p>[[50 - 100]% - Tier 3]</p> <p>[[50 - 100]% - Tier 4]</p> <p>[[50 - 100]% - Tier 5]</p> <p>[[50 - 100]% - Tier 6]</p>	<p>[Yes] [No]</p> <p>[Yes, except when provided during a Physician office visit]</p>	<p>[Yes] [No]</p> <p>[Yes, except when provided during a Physician office visit]</p>
<p>[21.] Physician Fees for Surgical and Medical Services</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 if group chooses to limit benefit. ¹Insert limit selected by group.</i></p> <ul style="list-style-type: none"> Well baby and well child care includes, but is 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 	<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</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>

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>years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years.</p> <p>No Copayment, Coinsurance or deductible will be applicable to Network or Non-Network children's immunizations.</p>	<p>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>		
<p>¹Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude. ²If Maternity Services are excluded, Complications of Pregnancy must always be included.</p> <p>[23.] Pregnancy - [¹Maternity Services] [²Complications of Pregnancy only]</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Always include Pre-service Notification Requirement except when notification is not required for any service.</i></p> <p>¹Include when benefits are provided for maternity services.</p> <p>²Include applicable Benefit level.</p> <p style="text-align: center;">[¹Pre-service Notification Requirement]</p> <p>[You must notify us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to notify us as required, Benefits will be reduced to [²50 - 95]% of Eligible Expenses.]</p> <p>³Include when benefits are provided for complications of pregnancy only.</p> <p>⁴Include applicable Benefit level.</p> <p style="text-align: center;">[⁴Pre-service Notification Requirement]</p> <p>[You must notify us five business days before admission for scheduled admissions or within one business day or the same day, or as soon as is reasonably possible for non-scheduled admissions. If you fail to notify us as required, Benefits will be reduced to [⁴50 - 95]% of Eligible Expenses.]</p> <p><i>Always include notification statement except when notification is not required for any service.</i></p> <p style="text-align: center;">[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> <p>[²Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>			
<p>[24.] Preventive Care Services</p>			
<p><i>Include when preventive care is limited and select the limit that applies.</i></p> <p>[Preventive care services are limited to \$[100 - 1,000] per year.]</p>	<p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to</p>

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Always include Pre-service Notification Requirement except when notification is not required for any service.</i></p> <p>¹<i>Include applicable Benefit level.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[You must notify us five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [¹50 - 95] % of Eligible Expenses.]</p> <p><i>Include if pre-admission notification is required.</i></p> <p>[In addition, you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]</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><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 notification is required for any rehabilitation service.</i></p> <p>¹<i>Include applicable Benefit level.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[You must notify us five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [vision therapy] or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [¹50 - 95] % of Eligible Expenses.]</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<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 Treatment.] • [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</i></p>	<p>[[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>limits apply.</i></p> <p>¹Include 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.</p> <p>²Include when vision therapy benefits are sold.</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 \$[750 - 12,000] per year.]</p> <p>Include when combined therapy visit limits apply separately to network benefits and to non-network benefits.</p>			
<p>[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic</p>			
<p><i>Include when notification is required for scopic procedures.</i></p> <p>¹Include applicable Benefit level.</p>			
<p align="center">[Pre-service Notification Requirement]</p> <p align="center">[You must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to [¹50 - 95]% of Eligible Expenses.]</p>			
	[50 - 100]%	[Yes] [No]	[Yes] [No]
<p>[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</p>			
<p><i>Always include Pre-service Notification Requirement except when notification is not required for any service.</i></p> <p>¹Include applicable Benefit level.</p>			
<p align="center">[Pre-service Notification Requirement]</p> <p align="center">[For a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to notify us as required, Benefits will be reduced to [¹50 - 95]% of Eligible Expenses.]</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Include if pre-admission notification is required.</i></p> <p>[In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>			
<p><i>Include limit selected by group.</i></p> <p>[Limited to [40 - 180] days per year.]</p>	<p>[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>
<p><i>Include for groups that purchase substance use disorder benefits. Include ONLY when group purchases plan with outpatient SA benefits with MH full parity or no MH. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing</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 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>[Yes] [No]</p>	<p>[Yes] [No]</p>
<p><i>Select from these limit options when limits apply only to Substance Use Disorder Services described in this section.</i></p> <p><i>[Inpatient/Intermediate Substance Use Disorder Services are limited to [10 -</i></p>	<p><i>[Outpatient]</i></p> <p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>100] days per year.]</p> <p>[Outpatient <i>Substance Use Disorder Services</i> are limited to [10 - 100] visits per year.]</p> <p>Select from these limit options when limits apply to <i>Substance Use Disorder Services</i> described in this section combined with <i>Mental Health Services</i> above.</p> <p>[Benefits for any combination of <i>Substance Use Disorder Services</i> described in this section and <i>Mental Health Services</i> described above 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>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.</p>			
<p>[31.] Surgery - Outpatient</p>			
<p>Include when notification is required.</p> <p>¹Include applicable Benefit level.</p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[For [all outpatient surgeries] [[blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators]] you must notify us five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
possible. If you fail to notify us as required, Benefits will be reduced to [150 - 95]% of Eligible Expenses.]			
	[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
<p><i>Include when group purchases TMJ benefit. This is a mandated benefit in Arkansas.</i></p> <p>[32.] [Temporomandibular Joint Services]</p>			
<p><i>Always include Pre-service Notification Requirement except when notification is not required for any service.</i></p> <p><i>¹Include applicable Benefit level.</i></p>			
<p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[You must notify us five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to notify us as required, Benefits will be reduced to [150 - 95]% of Eligible Expenses.]</p> <p><i>Include if pre-admission notification is required.</i></p> <p>[In addition, you must contact us 24 hours before admission for scheduled inpatient admissions.]</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>		
[33.] Therapeutic Treatments - Outpatient			
<p><i>Include when notification is required.</i></p> <p><i>¹Include applicable Benefit level.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[You must notify us [for all outpatient therapeutic services] [for the following outpatient therapeutic services] five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [Services that require notification: [dialysis] [,] [and] chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [hyperbaric oxygen therapy].] If you fail to notify us as required, Benefits will be reduced to [150 - 95]% of Eligible Expenses.]</p>			
	[50 - 100]%	[Yes] [No]	[Yes] [No]
[34.] Transplantation Services			
<p><i>Always include notification requirement except when notification is not required for any service.</i></p> <p><i>¹Include applicable Benefit level.</i></p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[You must notify us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to notify us as required, Benefits will be reduced to [150 - 95]% of Eligible Expenses.</p>			
<p><i>Include if pre-admission notification is required.</i></p>			
<p>[In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>			
	[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
<p>[35.] Urgent Care Center Services</p>			
<p><i>Include when urgent care services are limited and insert the limit selected by the group.</i></p> <p>[Limited to \$[100 - 5,000] per year.] [Limited to [2 - 10] visits per year.]</p>	[50 - 100]%	[Yes] [No]	[Yes] [No]
<p><i>Include when group purchases benefits for vision exams.</i></p>			
<p>[36.] [Vision Examinations]</p>			
<p>[Limited to [1 exam] [[2-3] exams] per year.] [Limited to [1 exam] [[2-3] exams] every [2 - 3] years.]</p>	[[50 - 100]%) [100% after you pay a Copayment of [\$5 - 75] per visit]	[Yes] [No]	[Yes] [No]
<p><i>Include when group purchases benefits for wigs.</i></p>			
<p>[37.] [Wigs]</p>			
<p><i>Include the limit selected by the group.</i></p> <p>[Limited to \$[100 - 1,000] per year.] [Limited to \$[100 - 5,000] every [24 - 36] months.]</p>	[[50 - 100]%)	[Yes] [No]	[Yes] [No]
<p>Additional Benefits Required By Arkansas Law</p>			
<p>[38.] Dental Services - Anesthesia and Hospitalization</p>			
<p><i>Always include Pre-service Notification Requirement except when notification is not required for any service.</i></p>			

[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> .]			
		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			
<i>Always include Pre-service Notification Requirement except when notification is not required for any service.</i>			
<i>¹Include applicable Benefit level.</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, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
Limited to a lifetime maximum of \$15,000.	[50 - 100%]	[Yes] [No]	[Yes] [No]
[40.] Medical Foods			
	<i>¹Include when group purchases the Outpatient Prescription Drug Rider.</i>	[Yes] [No]	[Yes] [No]
	Depending upon where the Covered Health Service is provided, Benefits will be [50 - 100]% [¹ or as provided under the <i>Outpatient Prescription Drug Rider</i>].		
<i>Mandated offer in Arkansas.</i>			
[[41.] Musculoskeletal Disorders of the Face, Neck or Head]			
<i>Always include Pre-service Notification Requirement except when notification is not required for any service.</i>			
[Pre-service Notification Requirement]			
[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> .]			
	[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> .]		
[42.] Orthotic Devices and Services			
<i>Include if notification is required.</i>			
<i>¹Include when notification applies only to orthotics that exceed a minimum dollar amount and insert</i>			

<i>applicable dollar amount.</i>			
<i>²Include applicable reduction in Benefits or no Benefits.</i>			
<p>[Pre-service Notification Requirement]</p> <p>[For 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 replacements are limited to a single purchase of each type of orthotic device every three years.	Network		
	[50 - 100%]	[Yes] [No]	[Yes] [No]
	Non-Network		
	[50 - 100%]	[Yes] [No]	[Yes] [No]

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Covered Health Services from non-Network providers, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. 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 is required and 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:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, [at our discretion,] based on [the lesser of]:

¹When using PHCS to determine Eligible Expenses, include the following and delete MNRP provisions.

- [¹For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
- When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [____]% of the amount that the *Centers for Medicare and Medicaid Services (CMS)* would have paid under the Medicare program for the drug determined by either of the following:
 - ◆ Reference to available CMS schedules.

- ◆ Methods similar to those used by CMS.
- Fee(s) that are negotiated with the provider.
- [50 - 100]% of the billed charge.
- A fee schedule that we develop.]

²When using MGRP to determine Eligible Expenses, include the following and delete PHCS provisions.

- [²Fee(s) that are negotiated with the provider.
- [____]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service [within the geographic market].
- [50 - 100]% of the billed charge.
- A fee schedule that we develop.]

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.

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.

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.

SERFF Tracking Number: UHLC-126253936

State: Arkansas

Filing Company: United HealthCare Insurance Company

State Tracking Number: 43119

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: 2009 AR Fed Forms Revisions

Project Name/Number: /

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	08/14/2009
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	08/14/2009
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	08/14/2009
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	08/14/2009
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved-Closed	08/14/2009
Comments:			
Attachment:			
Cover letter for Revision Sub.pdf			

August 04, 2009,

Via U.S. Mail

Rosalyn Minor

Arkansas Insurance Department

1200 West 3rd Street

Little Rock, Arkansas 72201

NAIC: 79413 United Healthcare Insurance Company

Form # SBN.CHP.I.09.AR

SBN.OPT.I.09.AR

SBN.NDF.I.09.AR

Dear Ms. Minor,

On behalf of United Healthcare Insurance Company, please accept this correspondence as a submission of the above revised forms for the Arkansas Insurance Department's ("the Department") review. These forms were granted approval July 6, 2009 and the revisions to the forms are as follows:

SBN.CHP.I.09.AR

SBN.OPT.I.09.AR

SBN.NDF.I.09.AR

- Mental Health Services and Substance Use Disorder Services have been removed from the section entitled, "Additional Benefits Required by Arkansas Law" as they already appear in the section entitled "Benefit Limits".
- A correction to the instructional text for the Orthotics Devices and Services mandate has been made whereby the word prosthetics had been replaced with the word orthotics.

SBN.NDF.I.09.AR

- A correction to the Pre-Service Benefit text for the Orthotics Devices and Services mandate has been made whereby the non-network reference has been deleted.

This submission has been submitted electronically via SERFF and United Healthcare Insurance Company 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 301.838.5611, through the SERFF messaging system or at Ebony_N_Terry@uhc.com.

Respectfully,

Ebony N. Terry
Compliance Analyst
Enclosure
ENT