Filing at a Glance

Company: United HealthCare Insurance Company

Product Name: 2009 Federal Legislation Filing
SERFF Tr Num: UHLC-126214630
State: Arkansas

TOI: H21 Health - Other
SERFF Status: Closed-Approved-Closed
State Tr Num: 42817

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: 09/29/2009

Date Submitted: 07/01/2009
Disposition Status: Approved-Closed

Implementation Date Requested:
Implementation Date:

State Filing Description:

General Information

Project Name:
Status of Filing in Domicile: Authorized

Project Number:
Date Approved in Domicile:

Requested Filing Mode:
Domicile Status Comments:

Explanation for Combination/Other:
Market Type: Group

Submission Type:
Group Market Size: Small and Large

Overall Rate Impact:
Group Market Type:

Filing Status Changed: 09/29/2009
Explanation for Other Group Market Type:

State Status Changed: 09/29/2009

Deemer Date:
Created By: Ebony Terry

Submitted By: Ebony Terry
Corresponding Filing Tracking Number:

Filing Description:
2009 Federal Legislation

Company and Contact

Filing Contact Information

Ebony Terry, Compliance Analyst
Ebony_N_Terry@uhc.com

4 Taft Court
301-838-5611 [Phone]

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

Filing Company Information

United HealthCare Insurance Company
450 Columbus Boulevard
PO Box 150450
Hartford, CT 06115-0450
(860) 702-5000 ext. [Phone]

CoCode: 79413
Group Code: 707
Group Name:
FEIN Number: 36-2739571

State of Domicile: Connecticut
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$650.00
Retaliatory?	No
Fee Explanation:	13 forms @ $50.00 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United HealthCare Insurance Company	$650.00	07/01/2009	28932215

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/29/2009	09/29/2009
Approved-Closed	Rosalind Minor	08/18/2009	08/18/2009
Approved-Closed	Rosalind Minor	07/06/2009	07/06/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Certificate of Coverage	Ebony Terry	09/27/2009	09/29/2009
Form	Schedule of Benefits Choice Plus	Ebony Terry	09/27/2009	09/29/2009
Form	Schedule of Benefits	Ebony Terry	09/27/2009	09/29/2009
Form	Schedule of Benefis Options PPO	Ebony Terry	09/27/2009	09/29/2009
Form	Certificate of Coverage	Ebony Terry	08/14/2009	08/14/2009

Disposition

Disposition Date: 09/29/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126214630*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*42817*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2009 Federal Legislation Filing*		
Project Name/Number:	*/*		

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
Supporting Document	Forms List	Approved-Closed	Yes
Form	Group Policy	Approved-Closed	Yes
Form *(revised)*	Certificate of Coverage	Approved-Closed	Yes
Form	Certificate of Coverage	Replaced	Yes
Form	Certificate of Coverage	Replaced	Yes
Form *(revised)*	Schedule of Benefits Choice Plus	Approved-Closed	Yes
Form	Schedule of Benefits Choice Plus	Replaced	Yes
Form *(revised)*	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Replaced	Yes
Form	Catalyst Rider	Approved-Closed	Yes
Form	Share RX Rider	Approved-Closed	Yes
Form	Share RX Schedule of Benefits	Approved-Closed	Yes
Form	Outpatient Prescription Drug Rider	Approved-Closed	Yes
Form	Outpatient Prescription Drug Rider Schedule of Benefits	Approved-Closed	Yes
Form	Outpatient Prescription Drug Rider Schedule of Benefits	Approved-Closed	Yes
Form	IRS Medical Care Rider	Approved-Closed	Yes
Form *(revised)*	Schedule of Benefis Options PPO	Approved-Closed	Yes
Form	Schedule of Benefis Options PPO	Replaced	Yes
Form	Notice of Change to Exhibit 2	Approved-Closed	Yes

Disposition

Disposition Date: 08/18/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126214630*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*42817*
Company Tracking Number:			
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Form *(revised)*	Certificate of Coverage	Approved-Closed	Yes
Form	Certificate of Coverage	Replaced	Yes
Form	Certificate of Coverage	Replaced	Yes
Form *(revised)*	Schedule of Benefits Choice Plus	Approved-Closed	Yes
Form	Schedule of Benefits Choice Plus	Replaced	Yes
Form *(revised)*	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Replaced	Yes
Form	Catalyst Rider	Approved-Closed	Yes
Form	Share RX Rider	Approved-Closed	Yes
Form	Share RX Schedule of Benefits	Approved-Closed	Yes
Form	Outpatient Prescription Drug Rider	Approved-Closed	Yes
Form	Outpatient Prescription Drug Rider Schedule of Benefits	Approved-Closed	Yes
Form	Outpatient Prescription Drug Rider Schedule of Benefits	Approved-Closed	Yes
Form	IRS Medical Care Rider	Approved-Closed	Yes
Form *(revised)*	Schedule of Benefis Options PPO	Approved-Closed	Yes
Form	Schedule of Benefis Options PPO	Replaced	Yes
Form	Notice of Change to Exhibit 2	Approved-Closed	Yes

Disposition

Disposition Date: 07/06/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126214630*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*42817*
Company Tracking Number:			
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Form *(revised)*	Certificate of Coverage	Approved-Closed	Yes
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Form *(revised)*	Schedule of Benefits Choice Plus	Approved-Closed	Yes
Form	Schedule of Benefits Choice Plus	Replaced	Yes
Form *(revised)*	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Replaced	Yes
Form	Catalyst Rider	Approved-Closed	Yes
Form	Share RX Rider	Approved-Closed	Yes
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Form	Outpatient Prescription Drug Rider	Approved-Closed	Yes
Form	Outpatient Prescription Drug Rider Schedule of Benefits	Approved-Closed	Yes
Form	Outpatient Prescription Drug Rider Schedule of Benefits	Approved-Closed	Yes
Form	IRS Medical Care Rider	Approved-Closed	Yes
Form *(revised)*	Schedule of Benefis Options PPO	Approved-Closed	Yes
Form	Schedule of Benefis Options PPO	Replaced	Yes
Form	Notice of Change to Exhibit 2	Approved-Closed	Yes

Amendment Letter

Submitted Date: 09/29/2009

Comments:

Dear Ms. Minor,

Per our conversation, I am submitting revisions to the Certificate of Coverage and Schedule of Benefit forms included in this filing. The purpose of these revisions are to include the AR Mandates for Hearing Aid benefits, Prostate Cancer Screening and to apply Mental Health Benefits to Small and Large Group. If you have any questions reagarding the revisons, please do not hestiate to contact me.

Thank you for your time

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
COC.CER.I.09.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Certificate of Coverage	Initial					X09I_COC final 9.25.09.pdf
SBN.CHP.I.09.AR	Schedule Pages	Schedule of Benefits Choice Plus	Initial					X09I_SBN_CHCPLS 9.25.09.pdf
SBN.NDF.I.09.AR	Schedule Pages	Schedule of Benefits	Initial					X09I_SBN_NONDIFF 9.25.09.pdf
SBN.OPT.I.09.AR	Schedule Pages	Schedule of Benefis Options PPO	Initial					X09I_SBN_OPT 9.25.09.pdf

Amendment Letter

Submitted Date: 08/14/2009

Comments:

Dear Ms. Minor,

Per our conversation I am submitting to you the necessary revisions that I needed to make to the COC. I hope that you find them acceptable. Should you have any questions or concerns, please let me know.

Thank you
Ebony N. Terry

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
COC.CER.I.09.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Certificate of Initial Coverage						X09I_COC.pdf X09I_COC final 8.7.09.pdf

Form Schedule

Lead Form Number: POL.H.09.AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/06/2009	POL.H.09.AR	Policy/Contract/Fraternal Certificate	Group Policy	Initial			X09I_POL.pdf
Approved-Closed 09/29/2009	COC.CER.I.09.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Certificate of Coverage	Initial			X09I_COC final 9.25.09.pdf
Approved-Closed 09/29/2009	SBN.CHP.I.09.AR	Schedule Pages	Schedule of Benefits Choice Plus	Initial			X09I_SBN_CHCPLS 9.25.09.pdf
Approved-Closed 09/29/2009	SBN.NDF.I.09.AR	Schedule Pages	Schedule of Benefits	Initial			X09I_SBN_NONDIFF 9.25.09.pdf
Approved-Closed 07/06/2009	CATL.I.09.AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Catalyst Rider	Initial			X09I_RDR_Catalyst-Catalyst Choice.pdf
Approved-Closed 07/06/2009	RDR.SHARERX.PLS.I.09.AR	Policy/Contract/Fraternal Certificate: Amendment, Insert	Share RX Rider	Initial			X09I_RDR_SHARERXPLS.pdf

		Page, Endorsement or Rider				
Approved-Closed 07/06/2009	RDR.SHARERXSBN.PLS.I.09.AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Share RX Schedule of Benefits	Initial		X09I_RDR_RXSBN-SHAREPLS.pdf
Approved-Closed 07/06/2009	RDR.GENRX.PLS.I.09	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Outpatient Prescription Drug Rider	Initial		X09I_RDR_RXGENPLS.pdf
Approved-Closed 07/06/2009	RDR.GENRXSBN.PLS.I.09.AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Outpatient Prescription Drug Rider Schedule of Benefits	Initial		X09I_RDR_RXSBN-GENPLS.pdf
Approved-Closed 07/06/2009	RDR.RXSBN.PLS.I.09.AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement	Outpatient Prescription Drug Rider Schedule of Benefits	Initial		X09I_RDR_RXSBN-PLS.pdf

Approved-Closed 07/06/2009	IRS.I.9.AR	nt or Rider Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	IRS Medical Care Rider	Initial		X09I_RDR_IRS.pdf
Approved-Closed 09/29/2009	SBN.OPT.I.09.AR	Schedule Pages	Schedule of Benefis Options PPO	Initial		X09I_SBN_OPT 9.25.09.pdf
Approved-Closed 07/06/2009	EXB2NTC.I.09.AR	Notice of Coverage	Notice of Change to Exhibit 2	Initial		X09I_NTC_POL_EXH2.pdf

Group Policy

UnitedHealthcare Insurance Company

[450 Columbus Boulevard]

[Hartford, Connecticut 06115-0450]

[1-800-357-1371]

This Policy is entered into by and between UnitedHealthcare Insurance Company and the "Enrolling Group," as described in Exhibit 1.

When used in this document, the words "we," "us," and "our" are referring to UnitedHealthcare Insurance Company.

Upon our receipt of the Enrolling Group's signed application and payment of the first Policy Charge, this Policy is deemed executed.

We agree to provide Benefits for Covered Health Services set forth in this Policy, including the attached *Certificate(s) of Coverage* and *Schedule(s) of Benefits*, subject to the terms, conditions, exclusions, and limitations of this Policy. The Enrolling Group's application is made a part of this Policy.

This Policy replaces and overrules any previous agreements relating to Benefits for Covered Health Services between the Enrolling Group and us. The terms and conditions of this Policy will in turn be overruled by those of any subsequent agreements relating to Benefits for Covered Health Services between the Enrolling Group and us.

We will not be deemed or construed as an employer or plan administrator for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer or plan administrator with respect to the Enrolling Group's benefit plan.

This Policy will become effective on the date specified in Exhibit 1 and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of this Policy as provided in Article 5.

When this Policy is terminated, as described in Article 5, this Policy and all Benefits under this Policy will end at 12:00 midnight on the date of termination.

This Policy is issued as described in Exhibit 1.

Issued By:

UnitedHealthcare Insurance Company

[Signature of authorized company officer]

[Title of authorized company officer]

Article 1: Glossary of Defined Terms

The terms used in this Policy have the same meanings given to those terms in *Section 9: Defined Terms* of the attached *Certificate(s) of Coverage*.

Coverage Classification - one of the categories of coverage described in Exhibit 2 for rating purposes (for example: Subscriber only, Subscriber and spouse, Subscriber and children, Subscriber and family).

Material Misrepresentation - any oral or written communication or conduct, or combination of communication and conduct, that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of a policy or coverage under a policy, calculation of rates, or payment of a claim.

Article 2: Benefits

Subscribers and their Enrolled Dependents are entitled to Benefits for Covered Health Services subject to the terms, conditions, limitations and exclusions set forth in the *Certificate(s) of Coverage* and *Schedule(s) of Benefits* attached to this Policy. Each *Certificate of Coverage* and *Schedule of Benefits*, including any Riders and Amendments, describes the Covered Health Services, required Copayments, and the terms, conditions, limitations and exclusions related to coverage.

Article 3: Premium Rates and Policy Charge

3.1 Premiums

Monthly Premiums payable by or on behalf of Covered Persons are specified in the Schedule of Premium Rates in Exhibit 2 of this Policy or in any attached Notice of Change.

We reserve the right to change the Schedule of Premium Rates as described in Exhibit 1 of this Policy. We also reserve the right to change the Schedule of Premium Rates at any time if the Schedule of Premium Rates was based upon a Material Misrepresentation relating to health status that resulted in the Premium rates being lower than they would have been if the Material Misrepresentation had not been made. We reserve the right to change the Schedule of Premium Rates for this reason retroactive to the effective date of the Schedule of Premium Rates that was based on the Material Misrepresentation.

3.2 Computation of Policy Charge

The Policy Charge will be calculated based on the number of Subscribers in each Coverage Classification that we show in our records at the time of calculation. The Policy Charge will be calculated using the Premium rates in effect at that time. Exhibit 1 describes the way in which the Policy Charge is calculated.

[1]Enter the appropriate number of days.

3.3 Adjustments to the Policy Charge

We may make retroactive adjustments for any additions or terminations of Subscribers or changes in Coverage Classification that are not reflected in our records at the time we calculate the Policy Charge. We will not grant retroactive credit for any change occurring more than [[1]30 - 90] days prior to the date we received notification of the change from the Enrolling Group. We also will not grant retroactive credit for any calendar month in which a Subscriber has received Benefits.

The Enrolling Group must notify us in writing within [[1]30 - 90] days of the effective date of enrollments, terminations, or other changes. The Enrolling Group must notify us in writing each month of any change in the Coverage Classification for any Subscriber.

If premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, those charges will automatically be added to the Premium. In addition, any change in law or regulation that significantly affects our cost of operation will result in an increase in Premium in an amount we determine.

Grace Period is mandatory in Arkansas

3.4 Payment of the Policy Charge

The Policy Charge is payable to us in advance by the Enrolling Group as described under "Payment of the Policy Charge" in Exhibit 1. The first Policy Charge is due and payable on or before the effective date of this Policy. Subsequent Policy Charges are due and payable no later than the first day of each payment period specified in item 6 of Exhibit 1, while this Policy is in force.

All payments shall be made in United States dollars, in immediately available funds, and shall be remitted to us at the address set forth in the Enrolling Group's application, or at such other address as we may from time to time designate in writing. The Enrolling Group agrees not to send us payments marked “paid in full”, “without recourse”, or similar language. In the event that the Enrolling Group sends such a payment, we may accept it without losing any of our rights under this Policy and the Enrolling Group will remain obligated to pay any and all amounts owed to us.

[1]Include text if late payment charge applies (it will apply if the grace period provision is included).

[2]Include text if grace period provision does not apply.

A late payment charge will be assessed for any Policy Charge not received [[1]within 10 calendar days following the due date.] [[2]by the due date.] A service charge will be assessed for any non-sufficient-fund check received in payment of the Policy Charge. All Policy Charge payments must be accompanied by supporting documentation that states the names of the Covered Persons for whom payment is being made.

The Enrolling Group must reimburse us for attorney's fees and any other costs related to collecting delinquent Policy Charges.

[1]Enter the appropriate number of days. Arkansas law requires a minimum of 31 days.

3.5 Grace Period

A grace period of [[1]31 - 90] days will be granted for the payment of any Policy Charge not paid when due. During the grace period, this Policy will continue in force. The grace period will not extend beyond the date this Policy terminates.

The Enrolling Group is liable for payment of the Policy Charge during the grace period. If we receive written notice from the Enrolling Group to terminate this Policy during the grace period, we will adjust the Policy Charge so that it applies only to the number of days this Policy was in force during the grace period.

This Policy terminates as described in Article 5.1 if the grace period expires and the past due Policy Charge remains unpaid.

Article 4: Eligibility and Enrollment

4.1 Eligibility Conditions or Rules

Eligibility conditions or rules for each class are stated in the corresponding Exhibit 2. The eligibility conditions stated in Exhibit 2 are in addition to those specified in *Section 3: When Coverage Begins* of the *Certificate of Coverage*.

4.2 Initial Enrollment Period

Eligible Persons and their Dependents may enroll for coverage under this Policy during the Initial Enrollment Period. The Initial Enrollment Period is determined by the Enrolling Group.

Include Open Enrollment Period unless a group chooses a closed plan.

[4.3] [Open Enrollment Period]

[An Open Enrollment Period will be provided periodically for each class, as specified in the corresponding Exhibit 2. During an Open Enrollment Period, Eligible Persons may enroll for coverage under this Policy.]

[4.4] Effective Date of Coverage

The effective date of coverage for properly enrolled Eligible Persons and their Dependents is stated in Exhibit 2.

Article 5: Policy Termination

5.1 Conditions for Termination of the Entire Policy

This Policy and all Benefits for Covered Health Services under this Policy will automatically terminate on the earliest of the dates specified below:

[1]Include if we choose to terminate coverage on the last day of the grace period.

[2]Include if we choose to terminate on the last paid date of coverage.

A. [[1]On the last day of the grace period if the Policy Charge remains unpaid. The Enrolling Group remains liable for payment of the Policy Charge for the period of time this Policy remained in force during the grace period.] [[2]At our option, retroactive to the last paid date of coverage if the Policy Charge remains unpaid on the due date.] [[3]At our option, retroactive to the last paid date of coverage if the grace period expires and the Policy Charge remains unpaid on the due date.]

B. On the date specified by the Enrolling Group, after at least 31 days prior written notice to us that this Policy is to be terminated.

Include when either contribution or participation rules apply.

[1]Include when both contribution and participation rules apply. [2]Include when either contribution or participation rules apply.

[C.] [On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated due to the Enrolling Group's violation of the participation [[1]and][[2]or] contribution rules as shown in Exhibit 1.]

[D]. On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated because the Enrolling Group provided us with false information material to the execution of this Policy or to the provision of coverage under this Policy. In this case, we have the right to rescind this Policy back to either:

- The effective date of this Policy.
- The date we received the false information, if later.

[E]. On the date we specify, after at least 90 days prior written notice to the Enrolling Group, that this Policy is to be terminated because we will no longer issue this particular type of group health benefit plan within the applicable market.

[F]. On the date we specify, after at least 180 days prior written notice to the applicable state authority and to the Enrolling Group, that this Policy is to be terminated because we will no longer issue any employer health benefit plan within the applicable market.

5.2 Payment and Reimbursement Upon Termination

Upon any termination of this Policy, the Enrolling Group is and will remain liable to us for the payment of any and all Premiums which are unpaid at the time of termination, including a pro rata portion of the Policy Charge for any period this Policy was in force during the grace period preceding the termination.

Article 6: General Provisions

6.1 Entire Policy

This Policy, including the *Certificate(s) of Coverage*, the *Schedule(s) of Benefits*, the application of the Enrolling Group, and any Amendments, Notices of Change, and Riders, constitute the entire Policy between the parties. All statements made by the Enrolling Group or by a Subscriber will, in the absence of fraud, be deemed representations and not warranties.

6.2 Dispute Resolution

No legal proceeding or action may be brought until the parties have attempted, in good faith, to resolve the dispute amongst themselves. In the event the dispute is not resolved within thirty (30) days after one party has received written notice of the dispute from the other party, and either party wishes to pursue the dispute further, the dispute may be submitted to arbitration as set forth below.

The parties acknowledge that because this Policy affects interstate commerce, the *Federal Arbitration Act* applies. If the Enrolling Group wishes to seek further review of the decision or the complaint or dispute, it must submit the decision, complaint or dispute to binding arbitration pursuant to the rules of the *American Arbitration Association*. This is the only right the Enrolling Group has for further consideration of any dispute that arises out of or is related to this Policy.

Arbitration will take place in [Hartford County, Connecticut].

The matter must be submitted to binding arbitration within one year of the date notice of the dispute was received. The arbitrators will have no power to award any punitive or exemplary damages or to vary or ignore the provisions of this Policy, and will be bound by controlling law.

6.3 Time Limit on Certain Defenses

No statement made by the Enrolling Group, except a fraudulent statement, can be used to void this Policy after it has been in force for a period of two years.

6.4 Amendments and Alterations

Amendments to this Policy are effective 31 days after we send written notice to the Enrolling Group. Riders are effective on the date we specify. Other than changes to Exhibit 2 stated in a Notice of Change to Exhibit 2, no change will be made to this Policy unless made by an Amendment or a Rider which is signed by one of our authorized executive officers. No agent has authority to change this Policy or to waive any of its provisions.

6.5 Relationship between Parties

The relationships between us and Network providers, and relationships between us and Enrolling Groups, are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees, nor are we or any of our employees an agent or employee of Network providers or Enrolling Groups.

The relationship between a Network provider and any Covered Person is that of provider and patient. The Network provider is solely responsible for the services provided by it to any Covered Person. The relationship between any Enrolling Group and any Covered Person is that of employer and employee, Dependent, or any other category of Covered Person described in the Coverage Classifications specified in this Policy.

The Enrolling Group is solely responsible for enrollment and Coverage Classification changes (including termination of a Covered Person's coverage) and for the timely payment of the Policy Charges.

6.6 Records

The Enrolling Group must furnish us with all information and proofs which we may reasonably require with regard to any matters pertaining to this Policy. We may at any reasonable time inspect:

- All documents furnished to the Enrolling Group by an individual in connection with coverage.
- The Enrolling Group's payroll.
- Any other records pertinent to the coverage under this Policy.

By accepting Benefits under this Policy, each Covered Person authorizes and directs any person or institution that has provided services to him or her, to furnish us or our designees any and all information and records or copies of records relating to the health care services provided to the Covered Person. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

We agree that such information and records will be considered confidential. We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy including records necessary for appropriate medical review and quality assessment or as we are required by law or regulation.

During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy for research and analytic purposes.

6.7 Administrative Services

The services necessary to administer this Policy and the Benefits provided under it will be provided in accordance with our standard administrative procedures or those standard administrative procedures of our designee. If the Enrolling Group requests that administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Enrolling Group must pay for such services or reports at the then current charges for such services or reports.

Delete if the group is not subject to ERISA.

[6.8] [Employee Retirement Income Security Act (ERISA)]

[When this Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the federal Employee Retirement Income Security Act 29 U.S.C., 1001 et seq., we will not be named as, and will not be, the plan administrator or the named fiduciary of the welfare plan, as those terms are used in ERISA.]

[6.9] Examination of Covered Persons

In the event of a question or dispute concerning Benefits for Covered Health Services, we may reasonably require that a Network Physician, acceptable to us, examine the Covered Person at our expense.

[6.10] Clerical Error

[1]The number here should match the adjustment period number used in Article 3.3.

Clerical error will not deprive any individual of Benefits under this Policy or create a right to Benefits. Failure to report enrollments will not be considered a clerical error and will not result in retroactive coverage for Eligible Persons. Failure to report the termination of coverage will not continue the coverage for a Covered Person beyond the date it is scheduled to terminate according to the terms of this Policy. Upon discovery of a clerical error, any necessary appropriate adjustment in Premiums will be made. However, we will not grant any such adjustment in Premiums or coverage to the Enrolling Group for more than [[1]30 - 90] days of coverage prior to the date we received notification of the clerical error.

[6.11] Workers' Compensation Not Affected

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

[6.12] Conformity with Law

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

[6.13] Notice

When we provide written notice regarding administration of this Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to Covered Persons on a timely basis.

Any notice sent to us under this Policy and any notice sent to the Enrolling Group must be addressed as described in Exhibit 1.

[6.14] Continuation Coverage

We agree to provide Benefits under this Policy for those Covered Persons who are eligible to continue coverage under federal or state law, as described in *Section 4: When Coverage Ends* of the *Certificate of Coverage*.

We will not provide any administrative duties with respect to the Enrolling Group's compliance with federal or state law. All duties of the plan sponsor or plan administrator remain the sole responsibility of the Enrolling Group, including but not limited to notification of COBRA and/or state law continuation rights and billing and collection of Premium.

[6.15] Certification of Coverage Forms

As required by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), we will produce certification of coverage forms for Covered Persons who lose coverage under this Policy. The Enrolling Group agrees to provide us with all necessary eligibility and termination data. Certification of coverage forms will be based on eligibility and termination data that the Enrolling Group provides to our eligibility systems in accordance with our data specifications, and which is available in our eligibility systems as of the date the form is generated. The certification of coverage forms will only include periods of coverage that we administer under this Policy.

[1]Include when COCs will be not be sent directly to the Subscribers, but will be sent to the Enrolling Group for it to distribute the COCs to the Subscribers.

[6.16] Subscriber's Individual Certificate

We will issue *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments to [[1]the Enrolling Group for delivery to] each covered Subscriber. The *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments will show the Benefits and other provisions of this Policy. In addition, you may have access to your *Certificate of Coverage(s)* and *Schedule(s) of Benefits* online at [www.myuhc.com].

[6.17] System Access

The term "systems" as used in this provision means our systems that we make available to the Enrolling Group to facilitate the transfer of information in connection with this Policy.

System Access

We grant the Enrolling Group the nonexclusive, nontransferable right to access and use the functionalities contained within the systems, under the terms set forth in this Policy. The Enrolling Group agrees that all rights, title and interest in the systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the systems will remain ours. In order to obtain access to the systems, the Enrolling Group will obtain, and be responsible for maintaining, at no expense to us, the hardware, software and Internet browser requirements we provide to the Enrolling Group, including any amendments to those requirements. The Enrolling Group is responsible for obtaining an internet service provider or other access to the Internet.

The Enrolling Group will not:

- Access systems or use, copy, reproduce, modify, or excerpt any of the systems documentation provided by us in order to access or utilize systems, for purposes other than as expressly permitted under this Policy.
- Share, transfer or lease its right to access and use systems, to any other person or entity which is not a party to this Policy.

The Enrolling Group may designate any third party to access systems on its behalf, provided the third party agrees to these terms and conditions of systems access and the Enrolling Group assumes joint responsibility for such access.

Security Procedures

The Enrolling Group will use commercially reasonable physical and software-based measures, and comply with our security procedures, as may be amended from time to time, to protect the system, its functionalities, and data accessed through systems from any unauthorized access or damage (including damage caused by computer viruses). The Enrolling Group will notify us immediately if any breach of the security procedures, such as unauthorized use, is suspected.

System Access Termination

We reserve the right to terminate the Enrolling Group's system access:

- On the date the Enrolling Group fails to accept the hardware, software and browser requirements provided by us, including any amendments to the requirements.
- Immediately on the date we reasonably determine that the Enrolling Group has breached, or allowed a breach of, any applicable provision of this Policy. Upon termination of this Policy, the Enrolling Group agrees to cease all use of systems, and we will deactivate the Enrolling Group's identification numbers and passwords and access to the system.

Exhibit 1

1. **Parties.** The parties to this Policy are UnitedHealthcare Insurance Company and _____, the Enrolling Group.

[1]Insert month, day and year.

2. **Effective Date of this Policy.** The effective date of this Policy is 12:01 a.m. on [[1]_____, ____] in the time zone of the Enrolling Group's location.

[1]Include For ERISA groups.

[2]Include for non-ERISA groups.

3. **Place of Issuance.** We are delivering this Policy in the State of Arkansas. [[1]This Policy is governed by ERISA. To the extent that state law applies, the laws of the State of Arkansas are the laws that govern this Policy.] [[2]The laws of the State of Arkansas are the laws that govern this Policy.]

[1]Include when premiums are specified in the Cost Summary.

[2]Include when the group has more than 1 class

[3]Select the appropriate length of time for prior written notice, based on group requirement.

[4]Select the text that describes when we have the right to change premium.

4. **Premiums.** We reserve the right to change the Schedule of Premium Rates [[1]or Cost Summary] specified in [[2]each] Exhibit 2, after a [[3]31 - 120]-day prior written notice [[4]on the first anniversary of the effective date of this Policy specified in the application or on any monthly due date thereafter, or on any date the provisions of this Policy are amended. We also reserve the right to change the Schedule of Premium Rates, retroactive to the effective date, if a Material Misrepresentation relating to health status has resulted in a lower schedule of rates.] [[4]at any time.]

[1]Select the paragraph that describes the applicable computation of the Policy Charge.

5. **Computation of Policy Charge.** [[1]A full calendar month's Premiums will be charged for Covered Persons whose effective date of coverage falls on or before the 15th of that calendar month. No Premiums will be charged for Covered Persons whose effective date of coverage falls after the 15th of that calendar month. A full calendar month's Premiums will be charged for Covered Persons whose coverage is terminated after the 15th of that calendar month. No Premiums will be charged for Covered Persons whose coverage is terminated on or before the 15th of that calendar month.]

   [[1]A pro rata Premium, calculated on the number of days Covered Persons are actually covered under this Policy, will be charged for Covered Persons whose effective date of coverage falls on a date other than the first of the month or for Covered Persons whose coverage is terminated on a date other than the first of the month.]

   [[1]A full month's Premium will be charged for any Covered Person who is covered under this Policy for any portion of a calendar month.]

[1]Select appropriate payment basis.

6. **Payment of the Policy Charge.** The Policy Charge is payable to us in advance by the Enrolling Group on a [[1]monthly] [[1]quarterly] [[1]semi-annual] [[1]annual] basis

NOTE: At least one of the minimum requirements below will always apply. For Catalyst/Catalyst Choice, include alternate #7 with combined participation and contribution requirement provision when 100% participation and contribution requirement applies and delete both separate requirement statements #7 and #8. When 100% combined participation and contribution requirements do not apply to Catalyst/Catalyst Choice, use separate options #7 and 8 below.

Include combined minimum participation and contribution requirement when the policy is issued for Catalyst/Catalyst Choice and when 100% participation and contribution requirement applies.

[7.] **[Minimum Participation and Contribution Requirements - [Catalyst] [Catalyst Choice]]**

[Participation in the [Catalyst] [Catalyst Choice] underlying medical plan is 100% of Eligible Persons after waivers for creditable coverage, with a minimum of 50% of all Eligible Persons before waivers.

The Enrolling Group contributes 100% of employee-only rate.

Participation and contribution requirements do not apply to optional coverage provided under the [Catalyst] [Catalyst Choice] Rider.]

Include #7 and #8 below with all products except when Catalyst/Catalyst Choice is sold (as defined above).

[1]Select if a minimum participation requirement is applicable to this group. Minimum participation requirements are set by us.

[2]Select if a minimum participation requirement is not applicable to this group.

Select only one option, either number or percentage, but not both.

[3]Select if number applies. If the group policy is issued to a large employer, the numerical requirement is adjusted to show the upper limit of the number of Eligible Persons included in a small employer group as defined by UHC. If the Policy is issued to a small employer, the numerical requirement is two, unless state law requires issuance to one life groups.

[4]Select if percentage applies.

[7.] **[Minimum Participation Requirement.]** [[1]The minimum participation requirement for the Enrolling Group is [[3] [2 - 101] Eligible Persons.] [[4][0 - 100]% of Eligible Persons excluding spousal waivers but no less than 50% of all Eligible Persons must be enrolled for coverage under this Policy.][[2]The Minimum Participation Requirement does not apply.]

[1]Select if a minimum contribution requirement is applicable to this group. Minimum contribution requirements are set by us.

[2]Select if a minimum contribution requirement is not applicable to this group.

[3]Enter the applicable percentage.

[8.] **[Minimum Contribution Requirement.]** [[1]The Enrolling Group must maintain a minimum contribution requirement of [3][0 - 100]% of the Premium for each Eligible Person.][[2]The Minimum Contribution Requirement does not apply.]

[9.] **Notice.** Any notice sent to us under this Policy must be addressed to:

_____

(Name of Issuing Entity)

_____

(Address)

_____

(City, State, Zip)

Any notice sent to the Enrolling Group under this Policy must be addressed to:

_____

(Enrolling Group)

_____

(Address)

_____

(City, State, Zip)

[10]. [____ Enrolling Group Number]

[1]Include when more than one class of Eligible Persons is covered.

[2]Choose the applicable class number

Exhibit 2 [[1]Class [[2]1-10]]

[3]Include when the group has more than 1 class

[[3]The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.]

[1]Enter when class description is entered directly in Exhibit 2.

[2]Enter when class description is included by reference to Application.

[3]Enter applicable class description.

1. **Class Description.**

   [1][[3]All full-time employees.] [2][See Application.]

Insert eligibility conditions in A and B below. If there are no specific eligibility conditions that apply, the default will show "none."

[1]Include when more than one class of Eligible Persons is covered.

2. **Eligibility.** The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* [[1]applicable to this class]:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

   [_____]

   B. Other:

   [_____]

Include Open Enrollment Period unless a group chooses a closed plan.

[1]Include this text if Open Enrollment Period applies to this class.

[2]Enter the applicable number of days in the Open Enrollment Period.

[3]Select the appropriate frequency of the open enrollment for this class.

[4]Include this text if Open Enrollment Period does not apply to this class.

[3]. **[Open Enrollment Period.** [[1]An Open Enrollment Period of at least [[2]30 - 60] days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on [[3]an annual basis] [[3]a quarterly basis] [[3]_____].][[4]No Open Enrollment Period applies to this class.]**]**

[1] Enter effective date of coverage.

[2] Select the applicable alternative.

[4]. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is [[1]_____].

For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is [[2]the day following the last day of the required waiting period.] [[2]the first day of the month following the last day of the required waiting period.] [[2]the date the Eligible Person joins the Enrolling Group.] [[2]the first day of the month following the date the Eligible Person joins the Enrolling Group.][[2]as determined by the Enrolling Group, _____.]

[1]Insert when rates are shown in Exhibit 2.

[2] *Insert effective date.*

[3] *Insert When rates are issued via the Cost Summary.*

[5]. **Schedule of Premium Rates.**

[[1]The Schedule of Premium Rates payable by or on behalf of this class of Covered Persons as of [[2]_____] is shown below:

[**Coverage Classification**	**Monthly Premium**
Subscriber Only	$XXX.XX
Subscriber and Spouse	$XXX.XX
Subscriber plus one Child	$XXX.XX
Subscriber plus Family	$XXX.XX]

Changes to this Schedule of Premium Rates and/or subsequent Schedules of Premium Rates will be attached to this Policy by means of a Notice of Change to Exhibit 2.]

[[3]Monthly Premiums payable by or on behalf of Covered Persons are specified in the Cost Summary]

[Exhibit 3 - Miscellaneous Provisions]

Certificate of Coverage

UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy

This Certificate of Coverage (Certificate) is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this *Certificate* the Policy includes:

- The *Group Policy*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document

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

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

Other Information You Should Have

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

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

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of Arkansas. The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of Arkansas are the laws that govern the Policy.

Introduction to Your Certificate

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

How to Use this Document

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

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 8: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

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

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

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

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*. You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

Don't Hesitate to Contact Us

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

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

Arkansas Insurance Department

[Consumer Services Division]

[1200 West Third Street]

[Little Rock, AR 72201-1904]

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

Your Responsibilities

Be Enrolled and Pay Required Contributions

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

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as a Subscriber or his or her Dependent as those terms are defined in *Section 9: Defined Terms*.

Your Enrolling Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy and receive Benefits. If you have questions about this, contact your Enrolling Group.

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

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

Decide What Services You Should Receive

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

Choose Your Physician

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

Pay Your Share

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

Pay the Cost of Excluded Services

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

Show Your ID Card

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

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

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

We have the discretion to do the following:

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

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

Pay for Our Portion of the Cost of Covered Health Services

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

Pay Network Providers

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

Pay for Covered Health Services Provided by Non-Network Providers

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

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

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

Offer Health Education Services to You

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

Certificate of Coverage Table of Contents

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Section 1: Covered Health Services

Benefits for Covered Health Services

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

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

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

[1]*Include when a Per Occurrence Deductible applies.*

- The amount you must pay for these Covered Health Services (including any Annual Deductible, [Per Occurrence Deductible,] Copayment and/or Coinsurance).

[1]*Include when an Annual Maximum Benefit applies.*

- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services[[1], any Annual Maximum Benefit,] and/or any Maximum Policy Benefit).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for notifying us or obtaining prior authorization.

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

Include when group purchases benefits for acupuncture services.

[1.] [Acupuncture Services]

[Acupuncture services for the following conditions:

- Pain therapy.
- Nausea that is related to surgery, Pregnancy or chemotherapy.

Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.
- Acupuncturist.]

[2.] Ambulance Services

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

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

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

Include when group purchases benefits for clinical trials.

[3.] [Clinical Trials]

[Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer.
- Cardiovascular disease (cardiac/stroke).
- Surgical musculoskeletal disorders of the spine, hip, and knees.

Include to support expanding clinical trial benefit to other diseases or disorders.

- [Other diseases or disorders for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.]

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be a qualifying clinical trial, a clinical trial must meet all of the following criteria:

- Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.

- *Agency for Healthcare Research and Quality (AHRQ)*.
- *Centers for Medicare and Medicaid Services (CMS)*.
- *Department of Defense (DOD)*.
- *Veterans Administration (VA)*.

- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.]

Include when group purchases CHD benefit.

[4.] [Congenital Heart Disease Surgeries]

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

Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

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

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

Include when group purchases accidental dental benefit.

[5.] [Dental Services - Accident Only]

[Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.

- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.]

[6.] Diabetes Services

Diabetes Self-Management Training is mandated in Arkansas.

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

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

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

Diabetic Self-Management Items

Include paragraph below when group purchases the drug rider.

[1]Include only when group purchases benefits for durable medical equipment.

[Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. [[1]An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment*.] Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider*.]

Include paragraph and bulleted list below when group does not purchase the drug rider.

[1]Include only when group does not purchase benefits for durable medical equipment.

[2]Include only when group purchases benefits for durable medical equipment.

[Insulin pumps [[1]that are not fully implanted into the body,] and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including, but not limited to:

- [[2]Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment*.]
- Blood glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.]

Include when group purchases durable medical equipment benefit.

[7.] [Durable Medical Equipment]

[Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.

- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

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

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

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

Include when benefits for speech aid devices and tracheo-esophageal voice devices are sold.

[Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.]

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

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

Benefits are available for repairs and replacement, except that:

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

Include when DME Benefit is tiered and tiers are not to be included in COC.

[To determine the Tiers to which Durable Medical Equipment are assigned, contact [www.myuhc.com] or *Customer Care* at the telephone number on your ID card.]

Include when DME Benefit is tiered and tiers are to be included in COC.

[Durable Medical Equipment in Tier 1 is any item not specifically outlined in Tiers 2 or 3 below.

Durable Medical Equipment in Tier 2 is limited to the items listed below and any necessary supplies:

- Oxygen.
- Tube feeding pumps.
- Negative pressure wound therapy pumps.
- Bi-level Positive Airway Pressure machines (BiPAPs).
- Bone growth stimulators.
- Pulse oximeters.
- Wearable automatic external defibrillators.
- Insulin pumps.
- Neuromuscular stimulators that we determine to be proven for use, and which are used as part of an approved rehabilitative program.

Include when benefits for speech aid devices and tracheo-esophageal voice devices are sold.

- [Speech aid devices and tracheo-esophageal voice devices.]

Durable Medical Equipment in Tier 3 is limited to the items listed below and any necessary supplies:

- Power wheel chairs.
- Ventilators.
- High frequency chest compression devices.
- Specialty beds for pressure reduction.]]

[8.] Emergency Health Services - Outpatient

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

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

[Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.]

Include as standard for groups of 2 to 15 and 15+.

[9.] Hearing Aids

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

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

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

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.

- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

[10.] Home Health Care

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

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

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

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

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

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

[11.] Hospice Care

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

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

[12.] Hospital - Inpatient Stay

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

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

[1]Include if RAPLs and consulting physicians are paid under the facility charge.

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

[2]Include if RAPLs and consulting physicians are paid under the Physician fee category.

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

Include when group purchases benefits for infertility services.

[13.] [Infertility Services]

[Services for the treatment of infertility when provided by or under the direction of a Physician, limited to the following procedures:

- Ovulation induction.
- Insemination procedures (Artificial Insemination (AI) and IntraUterine Insemination (IUI)).
- Assisted Reproductive Technologies (ART).
- Pre-implantation Genetic Diagnosis (PGD) for diagnosis of genetic disorders only.
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

To be eligible for Benefits, the Covered Person must meet all of the following:

- Have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35.
- Be under age 44, if female.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.]

[14.] Lab, X-Ray and Diagnostics - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office.

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office] include, but are not limited to:

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

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

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

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design supports paying the physician's office services benefit for Lab/X-ray performed in a physician's office.

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

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

[15.] Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

[1]Include when plan design has an office visit copayment and supports paying CT, PET, MRI, MRA and nuclear medicine benefit for services performed in a physician's office.

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

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

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design supports paying the physician's office services benefit for major diagnostics performed in a physician's office.

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

Include when group purchases plan with Mental Health benefits. [1]Include if group purchases SA benefits [Include as standard for groups of 2 to 15]

[16.] Mental Health Services

[Mental Health Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits for Mental Health Services include:

- Mental health evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Inpatient.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Individual, family and group therapeutic services.
- Crisis intervention.

[1]For groups not subject to Federal Parity requirements, include benefit conversion information if the group purchases option to convert inpatient days to intermediate care or transitional care. Delete for groups subject to Federal Parity requirements.

The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. [[1]When limits apply to inpatient or Intermediate Care services in the *Schedule of Benefits*, inpatient days may be converted to Intermediate Care (such as Partial Hospitalization/Day Treatment or Intensive Outpatient Treatment programs) or Transitional Care at the discretion of the Mental Health/Substance Use Disorder Designee.

One inpatient day is equivalent to:

[2]Adjust days according to plan parameters (standard is two sessions of partial hospitalization/day treatment; five sessions of intensive outpatient treatment; six outpatient visits; ten days of Transitional Care.

- One day at a Residential Treatment Facility.
- [[2]Two] sessions of Partial Hospitalization/Day Treatment.
- [[2]Five] sessions of Intensive Outpatient Treatment.
- [[2]Six] outpatient visits.
- [[2]Ten] days of Transitional Care.]

Referrals to a Mental Health Services provider are at the discretion of the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating all of your care.

Mental Health Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for *Mental Health Services*.

Include when group purchases plan with inpatient/intermediate MH/SA benefits

[1]Include if group purchases SA benefits

Special Mental Health Programs and Services

[1]Include for non-parity customers.

[2]Include for parity customers.

[3]Include if applicable.

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Mental Health Services Benefit. [[1]Depending on the type of programs or services available, the programs or services may be offered to you at no cost or as an exchange of Benefits. When offered as an exchange of Benefits for use of these programs or services, this exchange is based on the assignment of the program or service to either inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use and any associated Copayment, Coinsurance and deductible.] [[2]The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use.] Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care [[3]or through other pathways as described in the program introductions]. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.]

Include when group purchases plan with benefits for autism spectrum disorders. When Mental Health Benefits are included, core autism benefits will always be included because medical benefits for autism treatment are paid under the medical plan based on place of service (parity issue).

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

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

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

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available [[1]under the applicable medical Covered Health Services categories in this *Certificate*] [[2]as described under [autism benefit section name] below].

Benefits include:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Inpatient/24-hour supervisory care.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Individual, family, therapeutic group, and provider-based case management services.
- Psychotherapy, consultation, and training session for parents and paraprofessional and resource support to family.
- Crisis intervention.
- Transitional Care.

Include when expanded services for autism are sold.

[Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).]

Autism Spectrum Disorder services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for *Neurobiological Disorders - Autism Spectrum Disorder Services*.]

Include when group purchases benefits for obesity surgery.

[18.] [Obesity Surgery]

[1]Include when specific criteria apply to benefits for obesity surgery and when only the criterion for a BMI of greater than 40 applies.

[Surgical treatment of obesity when provided by or under the direction of a Physician [[1]when the Covered Person has a Body Mass Index (BMI) of greater than 40].

[2]Include when specific criteria apply to benefits for obesity surgery and when either criterion must be met.

[[2]Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met:]

- [[2]The Covered Person must have a Body Mass Index (BMI) of greater than 40.]

- [[2]The Covered Person must have a Body Mass Index (BMI) of greater than 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by, obesity.]]

Include when group purchases benefits for ostomy supplies.

[19.] [Ostomy Supplies]

[Benefits for ostomy supplies are limited to the following:

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

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

[1]*Include when group purchases benefits for infertility services.*

[20.] Pharmaceutical Products - Outpatient

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

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. [[1]Benefits under this section do not include medications for the treatment of infertility.]

Include only when benefits are tiered for Pharmaceutical Products.

[Pharmaceutical Products are assigned to various tiers. The *Prescription Drug List Management Committee* makes the final classification of a Pharmaceutical Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Pharmaceutical Product, as well as whether notification requirements should apply. Economic factors may include, but are not limited to, the Pharmaceutical Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Pharmaceutical Product.

NOTE: We may periodically change the placement of a Pharmaceutical Product among the tiers. These changes generally occur quarterly, but no more than six times per year. These changes may occur without prior notice to you. As a result of such changes, the tier status of a Pharmaceutical Product may change, and you may be required to pay more or less for that Pharmaceutical Product.

To determine the tiers to which Pharmaceutical Products are assigned, contact [www.myuhc.com] or *Customer Care* at the telephone number on your ID card. The amount that you are required to pay for Pharmaceutical Products will vary depending upon the tier to which the Pharmaceutical Product is assigned.]

Include when Step Therapy applies.

[Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[21.] Physician Fees for Surgical and Medical Services

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

[22.] Physician's Office Services - Sickness and Injury

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

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

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

Benefits under this section include allergy injections.

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

[1]Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office. [2]Include when only minor diagnostics are included under Physician's Office Services, but major diagnostics in a Physician's office are paid under the major diagnostic category.

[[1]Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. [[2]Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services.]]

[3]Include when plan design supports paying Benefits for lab/X-ray only under the Lab/X-ray benefit.

[[3]When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.]

[1]Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude.

[2]If Maternity Services are excluded, Complications of Pregnancy must always be included.

[23.] Pregnancy - [[1]Maternity Services] [[2]Complications of Pregnancy only]

[1]Include #1 below when Benefits are available for full Maternity Services and delete option #2 further below.

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

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

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

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

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

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

[2]*Include #2 below when Benefits are available only for Complications of Pregnancy and delete option #1 above.*

[[2]Benefits for Complications of Pregnancy include all Covered Health Services required for the non-obstetrical treatment of a condition related to a Complication of Pregnancy during a Pregnancy or during the post-partum period.

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

We will pay Benefits for an Inpatient Stay of at least 96 hours for the mother and newborn child following a non-elective cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than this minimum time frame.]

[24.] Preventive Care Services

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

Physician office services:

- Routine physical examinations.
- Well baby and well child care.
- Immunizations.
- Hearing screening.

Lab, X-ray or other preventive tests:

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

Prosthetics are a mandated benefit in Arkansas.

[25.] Prosthetic Devices and Services

Benefits are available for the evaluation and treatment of a condition that requires the use of a prosthetic device. Benefits are available for external prosthetic devices that replace a limb or a body part, limited to:

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

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

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

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

Benefits are available for repairs and replacement when necessitated by anatomical change or normal use except that:

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

[26.] Reconstructive Procedures

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

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

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

Include when group purchases rehabilitation services benefit.

[1]Include when group purchases benefits for manipulative treatment.

[27.] [Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment]]

[Short-term outpatient rehabilitation services, limited to:

- Physical therapy.
- Occupational therapy.

[1]Include when group purchases benefits for manipulative treatment.

- [[1]Manipulative Treatment.]
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.

[2]Include when group purchases benefits for vision therapy.

- [[2]Vision therapy.]

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

[1]Include when group purchases benefits for manipulative treatment.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. [[1]Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.]

[1]Include when benefits are not provided for Neurobiological Disorders - Autism Spectrum Disorder Services. [2]Include when benefits are provided for Neurobiological Disorders - Autism Spectrum Disorder Services.

Please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or [[1]autism spectrum disorders] [[2]Autism Spectrum Disorders].]

[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic

[1]Include when plan design has an office visit copayment and supports paying the scopic benefit for services performed in a physician's office.

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

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

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

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

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

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design does not support paying the scopic procedures benefit for services performed in a physician's office.

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

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

[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

[1]Include if RAPLs and consulting physicians are paid under the facility charge.

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

[2]Include if RAPLs and consulting physicians are paid under the Physician fee category.

- [[2]Benefits for Physician services, including consulting Physicians, anesthesiologists, pathologists and radiologists, are described under *Physician Fees for Surgical and Medical Services*.]

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

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

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

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

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

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

[Include as standard for groups of 2 to 15]

[30.] Substance Use Disorder Services

[Substance Use Disorder Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits for Substance Use Disorder Services include:

- Substance Use Disorder and chemical dependency evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Detoxification (sub-acute/non-medical).
- Inpatient.

- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Referral services.
- Medication management.
- Individual, family and group therapeutic services.
- Crisis intervention.

[1]For groups not subject to Federal Parity requirements, include benefit conversion information if the group purchases option to convert inpatient days to intermediate care or transitional care. Delete for groups subject to Federal Parity requirements.

The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. [[1]When limits apply to inpatient or Intermediate Care services in the *Schedule of Benefits*, inpatient days may be converted to Intermediate Care (such as Partial Hospitalization/Day Treatment or Intensive Outpatient Treatment programs) or Transitional Care at the discretion of the Mental Health/Substance Use Disorder Designee.

One inpatient day is equivalent to:

[2]Adjust days according to plan parameters (standard is two sessions of partial hospitalization/day treatment; five sessions of intensive outpatient treatment; six outpatient visits; ten days of Transitional Care.

- One day at a Residential Treatment Facility.
- [[2]Two] sessions of Partial Hospitalization/Day Treatment.
- [[2]Five] sessions of Intensive Outpatient Treatment.
- [[2]Six] outpatient visits.
- [[2]Ten] days of Transitional Care.]

Referrals to a Substance Use Disorder Services provider are at the discretion of the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating all of your care.

Substance Use Disorder Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for *Substance Use Disorder Services*.

Special Substance Use Disorder Programs and Services

[1]Include for non-parity customers.

[2]Include for parity customers.

[3]Include if applicable.

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Substance Use Disorder Services Benefit. [[1]Depending on the type of programs or services available, the programs or services may be offered to you at no cost or as an exchange of Benefits. When offered as an exchange of Benefits for use of these programs or services, this exchange is based on the assignment of the program or service to either inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use and any associated Copayment, Coinsurance and deductible.] [[2]The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category

of Benefit use.] Special programs or services provide access to services that are beneficial for the treatment of your Substance Use Disorder which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care [[3]or through other pathways as described in the program introductions]. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.]

[31.] Surgery - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the outpatient surgery benefit for services performed in a physician's office.

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

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

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

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

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design supports paying the physician's office services benefit for outpatient surgery performed in a physician's office.

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

[32.] Temporomandibular Joint Services

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

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

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

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

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

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include *FDA*-approved TMJ implants only when all other treatment has failed.

[33.] Therapeutic Treatments - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the therapeutic treatments benefit for services performed in a physician's office.

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office], including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

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

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

Benefits under this section include:

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

[2]Include when plan design supports paying the physician's office services benefit for therapeutic treatments performed in a physician's office.

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

[34.] Transplantation Services

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

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

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

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

[35.] Urgent Care Center Services

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

Include when group purchases benefits for vision exams.

[36.] [Vision Examinations]

[Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office.

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.]

Include when group purchases benefit for wigs.

[37.] [Wigs]

[Wigs and other scalp hair prosthesis regardless of the reason for hair loss.]

Additional Benefits Required By Arkansas Law

[38.] Dental Services - Anesthesia and Hospitalization

Covered Health Services for anesthesia and related hospital services in conjunction with a dental procedure, if the anesthesia and related hospital services are deemed medically necessary by the patient's Physician or dentist and the following conditions are met:

- The patient is a child age seven or younger who is diagnosed with a dental condition that requires certain dental procedures to be performed in a Hospital or Alternate Facility.
- The patient is diagnosed with a serious mental or physical condition or a significant behavioral problem as determined by the patient's Physician.

[39.] In Vitro Fertilization Services

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

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

[40.] Medical Foods

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

This is a mandated offer in Arkansas. If group chooses not to have this benefit, they must refuse this benefit in writing.

[[41.] Musculoskeletal Disorders of the Face, Neck or Head]

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

[[42.] Orthotic Devices and Services

Benefits are available for the evaluation and treatment of a condition that requires the use of an orthotic device.

Benefits are available for external orthotic devices that restore physiological function or cosmesis to you.

If more than one orthotic device can meet your functional needs, Benefits are available only for the orthotic device that meets the minimum specifications for your needs. If you purchase a orthotic device

that exceeds these minimum specifications, we will pay only the amount that we would have paid for the orthotic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

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

Benefits are available for repairs and replacement when necessitated by anatomical change or normal use except that:

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

Orthotic devices do not include a cane, crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that:

- Is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and
- Has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

This exclusion does not apply to orthotics that are described under Orthotic Devices and Services in Section 1: Covered Health Services.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

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

We do not Pay Benefits for Exclusions

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

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

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

Benefit Limitations

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

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

A. Alternative Treatments

[1]Remove acupuncture exclusion if group purchases acupuncture benefit.

1. Acupressure [[1]and acupuncture].
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.

[2]Include when group purchases benefits for manipulative treatment.

6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to [[2]Manipulative Treatment and] non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

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

Include when group purchases accidental dental benefit.

[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.] *Dental Services - Anesthesia and Hospitalization* for which Benefits are provided as described in *Section 1: Covered Health Services*.

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

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

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

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

Include when group purchases accidental dental benefit.

[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.] *Dental Services - Anesthesia and Hospitalization* for which Benefits are provided as described in *Section 1: Covered Health Services*.

Include when group purchases accidental dental benefit.

3. Dental implants, bone grafts, and other implant-related procedures. [This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.] *Dental Services - Anesthesia and Hospitalization* for which Benefits are provided as described in *Section 1: Covered Health Services*.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. This exclusion does not apply to orthotics as described under Durable Medical Equipment in Section 1: Covered Health Services.
3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

Include when the group purchases benefits for speech aid devices and tracheo-esophageal voice devices.

4. Devices and computers to assist in communication and speech [except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*].

5. Oral appliances for snoring.

Include when the group purchases benefits for prosthetics and delete variable exclusion #6 further below.

[6.] [Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.]

Include when the group purchases benefits for prosthetics.

[7.] [Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.]

Include when group does not purchase benefits for prosthetics and delete the variable exclusions #6 and 7 above.

[6.] [Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.]

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.

2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

E. Experimental or Investigational or Unproven Services

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

Include when the group purchases benefits for clinical trials.

[This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.]

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.

2. Nail trimming, cutting, or debriding.

3. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

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

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

[1]Include when group does not purchase benefits for durable medical equipment.

G. Medical Supplies [[1]and Equipment]

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

Include when group does not purchase benefits for ostomy supplies.

   - [Ostomy supplies.]

   This exclusion does not apply to:

Include only when group purchases benefits for durable medical equipment.

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

Include only when group purchases benefits for ostomy supplies.

   - [Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.]

[1]Include only when group purchases benefits for durable medical equipment.

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

Include when group does not purchase benefits for durable medical equipment.

[3.] [Medical equipment of any kind. This exclusion does not apply to insulin pumps for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.]

H. Mental Health

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

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

[2.] [Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.]*

[3.] [Mental Health Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.]

[4.] [Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.]

[5.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Use Disorder Designee.]

[6.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.]

[7.] [Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.]

[8.] [Learning, motor skills, and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

[9.] [Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

[1]Delete when group does not purchase MH benefits.

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

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

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

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

Include when plan does not include MH benefits.

[1]Include when the group provides MH benefits under a separate plan.

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

I. Neurobiological Disorders - Autism Spectrum Disorders

When group purchases autism coverage, keep exclusions 1-10 and delete exclusion #11. When group does not purchase autism coverage, keep exclusions 9 (except for the text variable) and 11, delete all remaining exclusions.

[1.] [Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

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

[3.] [Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.]

[4.] [Mental retardation as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

[5.] [Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.]

[6.] [Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.]

[7.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Use Disorder Designee.]

Delete when benefits are purchased for expanded autism spectrum disorder.

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

[1]Delete when group does not purchase MH benefits.

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

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

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

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

Include when plan does not include autism spectrum disorder benefits.

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

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

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
   - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2 Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to medical foods for which Benefits are provided as described in *Section 1: Covered Health Services*

3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

K. Personal Care, Comfort or Convenience

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

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

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

Delete when group purchases optional benefit for weight loss.

[5.] [Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.]

Delete if group purchases benefits for wigs.

[6.] [Wigs regardless of the reason for the hair loss.]

Preexisting Condition Exclusion. Retain exclusion below when group purchases preexisting condition exclusion. Delete entire exclusion when group does not select preexisting condition exclusion. (Also modify Section 9 by deleting definitions of Continuous Creditable Coverage and Preexisting Condition.)

[M. Preexisting Conditions]

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

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

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

[2]This paragraph will be included when group chooses to apply a 12-month preexisting condition exclusion to "timely adds" and an 18-month preexisting condition exclusion to Late Enrollees. If this applies, make corresponding changes related to Late Enrollees in Sections 3 and 9.

[1.] [[2]Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following:

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

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

[3]This paragraph will be included when group chooses to apply the preexisting condition exclusion to Late Enrollees only. If this applies, make corresponding changes related to Late Enrollees in Sections 3 and 9.

[4]Select either 12 or 18 month period.

[1.] [[3]Benefits for the treatment of a Preexisting Condition are excluded for Late Enrollees until the date you have had Continuous Creditable Coverage for [[4]12] [[4]18] months.

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

N. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

Include when group purchases rehabilitation services benefit. [1]Include when rehabilitation services category includes benefits for manipulative treatment.

[4.] [Rehabilitation services [[1]and Manipulative Treatment] to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including but not limited to routine, long-term or maintenance/preventive treatment.]

Include when group purchases rehabilitation services benefits.

[1]Include when benefits are not provided for Neurobiological Disorders - Autism Spectrum Disorder Services. [2]Include when benefits are provided for Neurobiological Disorders - Autism Spectrum Disorder Services.

[5.] [Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or [[1]autism spectrum disorders] [[2]Autism Spectrum Disorders].]

Include when group does not purchase rehabilitation services benefits.

[5.] [Outpatient rehabilitation services. Examples include physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy, manipulative treatment, post-cochlear implant aural therapy and vision therapy.]

[6.] Psychosurgery.

[7.] Sex transformation operations.

[8.] Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

[9.] Biofeedback.

Include when group purchases rehabilitation services benefits that do not include manipulative treatment.

[10.] [Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function).]

Include unless group purchases optional benefit for TMJ treatment.

[11.] [Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.]

Include when group purchases optional benefit for TMJ treatment.

[11.] [The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.]

[1]Include if group purchases optional benefit for Musculoskeletal Disorders.

[12.] Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea. [[1]This exclusion does not apply to Musculoskeletal Disorders of the Face, Neck or Head for which Benefits are provided as described in *Section 1: Covered Health Services* under *Additional Benefits Required By Arkansas Law*.]

Delete exclusion #12 below if the group purchases benefits for both obesity surgery and weight loss programs.

[1]Include when group does not purchase optional benefit for obesity treatment of any kind. [2]Include when group purchases optional benefit for obesity surgery, but not weight loss programs.[3]Include when group purchases optional benefit for only weight loss programs, but not obesity surgery.

[13.] [[1]Surgical and non-surgical treatment of obesity.] [[2]Non-surgical treatment of obesity.] [[3]Surgical treatment of obesity.]

Include unless group purchases smoking cessation benefits.

[14.] [Stand-alone multi-disciplinary smoking cessation programs.]

Include when group does not purchase optional benefit for Breast Reduction.

[15.] [Breast reduction except as coverage is required by the *Women's Health and Cancer Right's Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.]

Include when group purchases optional benefit for Breast Reduction.

[16.] [Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Right's Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.]

O. Providers

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

   This exclusion does not apply to mammography.

[1]Delete exclusion when benefits for infertility treatment are sold. [2]When Benefits for infertility treatment are sold, always delete the exclusion for fetal reduction surgery.

[3]Remove all bracketed text to provide benefits for voluntary sterilization, pregnancy termination, and contraceptive supplies and other services. For groups that choose to modify, remove brackets as applicable to describe which of these services the group has chosen to exclude.

P. Reproduction

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

[2]This paragraph will be included only when group purchases Infertility Services benefit. Delete if benefits for Infertility Services are not purchased.

   [[2]The following infertility treatment-related services:
   - Cryo-preservation and other forms of preservation of reproductive materials.
   - Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue.
   - Donor services.]
2. Surrogate parenting, donor eggs, donor sperm and host uterus.

[1]Include when group does not purchase infertility benefit.

3. [[1]Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.]

[4.] The reversal of voluntary sterilization [[3]and voluntary sterilization].

[5.] [[3]Health services and associated expenses for surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).]

[6.] [[3]Contraceptive supplies and services.]

[7.] [[3]Fetal reduction surgery.]

Include the following if group is excluding coverage for maternity benefits. This option is available only to groups with 14 or fewer employees.

[8.] [Maternity related medical services for prenatal care, postnatal care and delivery (other than a non-elective cesarean delivery).]

Include the following if group excludes maternity benefits for enrolled dependent children.

[9.] [Maternity related medical services for Enrolled Dependent children.]

Q. Services Provided under another Plan

[1]Include when 24 hour coverage is not sold and delete #4 (24 hour coverage option) below.

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

[2]Include when group purchases MH benefits. [3]Include when group does not purchase MH benefits.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or [[2]Mental Illness] [[3]mental illness] that would have been covered under workers' compensation or similar legislation had that coverage been elected.]

[4]Include when 24 hour coverage is sold and delete option #1 above.

[[4]Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.]

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

3. Health services while on active military duty.

R. Substance Use Disorders

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

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

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

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

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

[1]Delete when group does not purchase SUD benefits.

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

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

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

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

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

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

Include when plan does not include SUD benefits.

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

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

S. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.

Always include #4 for network only plans. For plans with Network and Non-Network benefits, include exclusion #4 when Non-Network transplant benefits are not available and plan design requires transplants to take place at Designated Facilities. Never include exclusion #4 for plans that do not differentiate benefits by network/non-network status.

[4.] [Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.]

T. Travel

Include as standard; delete when product design includes services provided outside the US and its territories.

1. [Health services provided in a foreign country, unless required as Emergency Health Services.]

[2.] Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion.

U. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care* in *Section 1: Covered Health Services*.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

V. Vision and Hearing

1. Purchase cost and fitting charge for eye glasses and contact lenses.

Include when group does not purchase benefits for vision exams.

[2.] [Routine vision examinations, including refractive examinations to determine the need for vision correction.]

[3.] Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

Delete exclusion when benefits for vision therapy are provided.

[4.] [Eye exercise or vision therapy.]

[5.] Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

Include as standard only for groups of 15+.

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

- For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

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

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

Include as standard for groups under 15.

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

W. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*.

2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:

[1]Delete when Benefits are provided for immunizations for travel.

[2]Delete when Benefits are provided for immunizations for career and employment.

   - Required solely for purposes of school, sports or camp [[1], travel,] [[2]career or employment,] insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research.
   - Required to obtain or maintain a license of any type.

3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.

5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.

6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.

7. Charges in excess of Eligible Expenses or in excess of any specified limitation.

8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.

9. Autopsy.

10. Foreign language and sign language services.

Section 3: When Coverage Begins

How to Enroll

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

If You Are Hospitalized When Your Coverage Begins

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

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

Include if Medicare estimating applies.

[1]Include if Medicare estimating applies only to Medicare Parts A and B. [2]Include if Medicare estimating applies to Medicare Parts A, B and D. [3]Include if Medicare estimating applies only to Medicare Part D.

[If You Are Eligible for Medicare]

[Your Benefits under the Policy may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under [[1]both Medicare Part A and Part B] [[2]Medicare Part A, Part B and Part D] [[3]Medicare Part D].

Your Benefits under the Policy may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but fail to follow the rules of that plan. Please see *Medicare Eligibility* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.]

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Enrolling Group who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see *Section 9: Defined Terms*.

Include when U.S. residency is required.

[Eligible Persons must reside within the United States.]

Delete when group purchases double coverage.

[If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.]

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

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

Delete when group purchases double coverage.

[If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.]

When to Enroll and When Coverage Begins

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

Initial Enrollment Period

When the Enrolling Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

Include Open Enrollment Period unless a group chooses a closed plan.

[Open Enrollment Period]

[The Enrolling Group determines the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.]

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

[1]Include only if coverage is selected for domestic partners.

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- [[1]Registering a Domestic Partner.]

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

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

[1]*Include only if coverage is selected for domestic partners.*

[2]*Include when group chooses an Open Enrollment Period provision.*

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- [[1]Registering a Domestic Partner.]

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period [[2]or Open Enrollment Period] if the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period [[2]or Open Enrollment Period]; and
- Coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including, but not limited to, legal separation, divorce or death).
  - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  - In the case of COBRA continuation coverage, the coverage ended.
  - The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
  - The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
  - An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.
  - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth or marriage), coverage begins on the date of the event if we receive the completed enrollment form, any required Premium, and are notified within 90 days of the birth, 60 days of the adoption or placement for adoption or 31 days of the court or administrative order or marriage.

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For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period [[2]or Open Enrollment Period] because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Include if group chooses to allow Late Enrollees to enroll and applies the Late Enrollee preexisting condition. Make corresponding changes related to Late Enrollees in Sections 2 and 9.

[Late Enrollees]

[A Late Enrollee is an Eligible Person or Dependent who does not enroll for coverage under the Policy when he or she is first eligible, and who does not enroll during the Initial Enrollment Period [[2], Open Enrollment Period,] or a special enrollment period as described above.

Coverage for a Late Enrollee begins on the date agreed to by the Enrolling Group after we receive the completed enrollment form and any required Premium.]

Section 4: When Coverage Ends

General Information about When Coverage Ends

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

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. This does not apply if you are an inpatient in a Hospital on the date your coverage under the Policy would otherwise end as described under *Extended Coverage if You are Hospitalized*.

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

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

Include if Extended Coverage for Total Disability is included.

[Please note that for Covered Persons who are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.]

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

Throughout this section, select appropriate option for "date" or "last day of the calendar month in which" and delete the other.

- **You Are No Longer Eligible**

  Your coverage ends on the [date][last day of the calendar month in which] you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for complete definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

  Your coverage ends the [date][last day of the calendar month in which] the Subscriber is retired or receiving benefits under the Enrolling Group's pension or retirement plan. The Enrolling Group is responsible for providing written notice to us to end your coverage.

  This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is available for retirees.

Other Events Ending Your Coverage

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

- **Fraud, Misrepresentation or False Information**

  Fraud or misrepresentation, or the Subscriber knowingly gave us false material information. Examples include false information relating to another person's eligibility or status as a Dependent.

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

- **Material Violation**

  There was a material violation of the terms of the Policy.

- **Threatening Behavior**

  You committed acts of physical or verbal abuse that pose a threat to our staff.

Coverage for a Disabled Dependent Child

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

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Subscriber for support.

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

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

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

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

Include when Full-time Student status is required for Dependents.

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

[Extended Coverage for Full-time Students]

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

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

Coverage will be extended only when the Enrolled Dependent is covered under the Policy because of Full-time Student status [[1]at a post-secondary school] immediately before the medically necessary leave

of absence begins and when the Enrolled Dependent's change in Full-time Student status meets all of the following requirements:

- The Enrolled Dependent is suffering from a serious Sickness or Injury.
- The leave of absence [[1]from the post-secondary school] is medically necessary, as determined by the Enrolled Dependent's treating Physician.
- The medically necessary leave of absence causes the Enrolled Dependent to lose Full-time Student status for purposes of coverage under the Policy.

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

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

Include when Enrolling Group purchases extended coverage.

[Extended Coverage for Total Disability]

[Coverage for a Covered Person who is Totally Disabled on the date the entire Policy is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.

[1]Insert applicable number of months.

- [[1]Three - Eighteen] months from the date coverage would have ended when the entire Policy was terminated.]

Extended Coverage if You are Hospitalized

This provision is applicable only if the Policy terminates and is replaced by a group health insurance policy or contract issued by another insurer or by a self-funded health care plan. However, the extension of coverage does not apply if termination of the Policy occurs due to non-payment of Premium or fraud.

If you are an inpatient in a Hospital or other inpatient facility on the date your coverage under the Policy would otherwise terminate as described in the paragraph above, coverage will be extended until the earlier of:

The date your Inpatient Stay ends, or

The date you have exhausted the Inpatient Stay benefits under the Policy.

Continuation of Coverage and Conversion

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Enrolling Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Qualifying Events for Continuation Coverage under State Law

Coverage must have ended due to one of the following qualifying events:

- Termination of the Subscriber from employment with the Enrolling Group for any reason except gross misconduct.
- Termination of coverage due to loss of eligibility as a Subscriber or an Enrolled Dependent.

Notification Requirements and Election Period for Continuation Coverage under State Law

The Enrolling Group will provide you with written notification of the right to continuation coverage when coverage ends under the Policy. You must elect continuation coverage after receiving this notification. You should obtain an election form from the Enrolling Group or the employer and, once election is made, forward all monthly Premiums to the Enrolling Group for payment to us.

Terminating Events for Continuation Coverage under State Law

Continuation coverage under the Policy will end on the earliest of the following dates:

- 120 days from the date your continuation began.
- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date coverage is or could be obtained under any other group health plan.
- The date the Policy ends.

Conversion

If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

Application and payment of the initial Premium must be made within 31 days after coverage ends under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

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

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

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

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

Required Information

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

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

[1]Include when Outpatient Prescription Drug Benefits are sold.

The above information should be filed with us at the address on your ID card. [[1]When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Include the name and address of the appropriate Pharmacy Benefit Manager.

[Name of Pharmacy Benefit Manager]

[Address of Pharmacy Benefit Manager]

[City, State and Zip Code]]

Payment of Benefits

[1]Include the following provision and delete option #2 below if assignment of benefits is agreed to.

[[1]If a Subscriber provides written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber. But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.]

Include the following provision and delete option #1 above if assignment of benefits is not agreed to.

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

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

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

Section 6: Questions, Complaints and Appeals

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

What to Do if You Have a Question

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

What to Do if You Have a Complaint

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

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

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

How to Appeal a Claim Decision

Post-service Claims

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

Pre-service Requests for Benefits

[1]*Include if pre-service benefit notification includes determining alternate levels of benefits.*

Pre-service requests for Benefits are those requests that require notification or benefit confirmation prior to receiving medical care. [[1]If we adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols and standard cost-effectiveness analysis, you may appeal that decision pursuant to this process.]

How to Request an Appeal

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

Your request for an appeal should include:

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

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

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination.

We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits.

Appeals Determinations

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

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

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

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

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

Urgent Appeals that Require Immediate Action

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

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

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

Voluntary External Review Program

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

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

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

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

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations

are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse.

(c) The Plan covering the non-Custodial Parent.

(d) The Plan covering the non-Custodial Parent's spouse.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Include if Medicare estimating applies.

[1]Include if Medicare estimating applies only to Medicare Parts A and B. [2]Include if Medicare estimating applies to Medicare Parts A, B and D. [3]Include if Medicare estimating applies only to Medicare Part D.

[C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare [[1]Parts A and B] [[2]Parts A, B and D] [[3]Part D].
- The person is enrolled in a *Medicare Advantage* (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits

are determined as if the services were covered under Medicare [[1]Parts A and B] [[2]Parts A, B and D] [[3]Part D].

- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare [[1]Parts A and B] [[2]Parts A, B and D] [[3]Part D] and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a *Medicare Medical Savings Account*. Medicare benefits are determined as if the person were covered under Medicare [[1]Parts A and B] [[2]Parts A, B and D] [[3]Part D].]

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Section 8: General Legal Provisions

Your Relationship with Us

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

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

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

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

Our Relationship with Providers and Enrolling Groups

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

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

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of the termination of the Policy.

When the Enrolling Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers and Enrolling Groups

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

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

The relationship between you and the Enrolling Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

Statements by Enrolling Group or Subscriber

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

Incentives to Providers

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

Examples of financial incentives for Network providers are:

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

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

Incentives to You

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

Rebates and Other Payments

[1]Include when rebates are passed on to Covered Persons. [2]Include when rebates are not passed on to Covered Persons.

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable Annual Deductible. We [[1]do] [[2]do not] pass these rebates on to you, [[1]and they are applied to any Annual Deductible and] [[2]nor are they applied to any Annual Deductible or] taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits

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

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

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

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

Administrative Services

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

Amendments to the Policy

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

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

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

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.

- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

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

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

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

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

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

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

Examination of Covered Persons

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

Workers' Compensation not Affected

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

Include if Medicare estimating applies.

[1]Include if Medicare estimating applies only to Medicare Parts A and B. [2]Include if Medicare estimating applies to Medicare Parts A, B and D. [3]Include if Medicare estimating applies only to Medicare Part D.

[Medicare Eligibility]

[Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Policy.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under [[1]both Medicare Part A and Part B] [[2]Medicare Parts A, B and D] [[3]Medicare Part D]. If you don't enroll and maintain that coverage, and if we are the secondary

payer as described in *Section 7: Coordination of Benefits*, we will pay Benefits under the Policy as if you were covered under [[1]both Medicare Part A and Part B] [[2]Medicare Parts A, B and D] [[3]Medicare Part D]. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.]

Subrogation and Reimbursement

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

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

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

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

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by us,
  - signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim,
  - responding to requests for information about any accident or injuries,
  - making court appearances, and
  - obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.

- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate, and your heirs.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

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

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

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

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

Limitation of Action

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

Entire Policy

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

Section 9: Defined Terms

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

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

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

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

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

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

Include only when an Annual Maximum Benefit applies.

[**Annual Maximum Benefit** - for Benefit plans that have an Annual Maximum Benefit, this is the maximum amount that we will pay for Benefits during the year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Annual Maximum Benefit and for details about how the Annual Maximum Benefit applies.]

Include when benefit for Infertility Services is sold.

[**Assisted Reproductive Technology (ART)** - the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).]

Include when benefits for Mental Health Services for Autism Spectrum Disorders are purchased.

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

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

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

Include when the group purchases benefits for complications of pregnancy.

[**Complications of Pregnancy** - a condition that requires treatment during a Pregnancy or during the post-partum period.]

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

Include definition for groups that purchase Preexisting Condition exclusion.

[**Continuous Creditable Coverage** - health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services, and for their dependents.
- A medical care program of the *Indian Health Services Program* or a tribal organization.
- A state health benefits risk pool.
- *The Federal Employees Health Benefits Program*.
- *The State Children's Health Insurance Program (S-CHIP)*.
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the *Peace Corps Act*.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.]

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

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

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

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

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, [[1]Mental Illness,][[2]mental illness,] substance use disorders, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.

- Described in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

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

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

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

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

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

[1]Include bracketed text if group purchases Domestic Partner coverage.

Dependent - the Subscriber's legal spouse or an unmarried dependent child of the Subscriber or the Subscriber's spouse. [[1]All references to the spouse of a Subscriber shall include a Domestic Partner.] The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

Include if group chooses to include the parents of the Subscriber as Dependents. [1]Include if group chooses to include the parents of the Subscriber's spouse as Dependents.

[The definition of Dependent also includes parents of the Subscriber [[1]or the Subscriber's spouse].]

Include when U.S. residency is required.

[To be eligible for coverage under the Policy, a Dependent must reside within the United States.]

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

[1]Modify age as appropriate to accommodate group decision.

- A Dependent includes any unmarried dependent child under [[1]18-19] years of age.

[2-3-4]Delete #2 if group does not use Full-time Student criteria and include #3 below for IRS criteria (cannot exceed age 24) or #4 if IRS criteria does not apply. Modify ages as appropriate to accommodate group decision.

- [[2]A Dependent includes an unmarried dependent child who is [[1]18 - 19] years of age or older, but less than [[1]23 - 30] years of age only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - The child must not be regularly employed on a full-time basis.
  - The child must be a Full-time Student.
  - The child must be primarily dependent upon the Subscriber for support and maintenance.]
- [[3]A Dependent includes an unmarried dependent child who is [[1]18 - 19] years of age or older, but less than [[1]23 - 24] years of age only if the child meets the Internal Revenue Service definition of a "qualifying child" or a "qualifying relative."]
- [[4]A Dependent includes an unmarried dependent child who is [[1]18 - 19] years of age or older, but less than [[1]23 - 30] years of age only if both of the following are true:
  - The child is not regularly employed on a full-time basis.
  - The child is primarily dependent upon the Subscriber for support and maintenance.]
- A Dependent includes an unmarried dependent child of any age who is or becomes disabled and dependent upon the Subscriber.

Include paragraph below when group intends to allow coverage for a dependent child until the last day of the year in which he/she reaches the limiting age. If different limits apply to Full-time Student, use language in that provision to address the full-time student criteria and the provision below to address the other dependent children.

[A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the child's [[1]18 - 30th] birthday.]

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

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

Include when the group does not elect double coverage.

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

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

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

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

Include following two definitions for groups that purchase domestic partner coverage.

Modify text for partners of the [1]"opposite sex,"[2]"same sex,"[3]"opposite or same sex."

[Domestic Partner - a person of the [[1]opposite sex][[2]same sex][[3]opposite or same sex] with whom the Subscriber has established a Domestic Partnership.]

[Domestic Partnership - a relationship between a Subscriber and one other person of the [[1]opposite sex][[2]same sex][[3]opposite or same sex]. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.

[1]Include if group requires documentation of financial interdependence. If necessary, modify conditions of financial interdependence to support group's requirements.

- They must be financially interdependent [[1]and they have furnished documents to support at least two of the following conditions of such financial interdependence:
  - They have a single dedicated relationship of at least [6 - 18] months duration.
  - They have joint ownership of a residence.
  - They have at least two of the following:
    - A joint ownership of an automobile.
    - A joint checking, bank or investment account.
    - A joint credit account.
    - A lease for a residence identifying both partners as tenants.
    - A will and/or life insurance policies which designates the other as primary beneficiary].

[2]Include if group requires signed affidavit.

[[2]The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.]]

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

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

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

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

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

[1]Include when U.S. residency is required.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. [[1]An Eligible Person must reside within the United States.]

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

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or [[1]Mental Illness][[2]mental illness] which is both of the following:

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

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

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

Enrolling Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

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

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

Exceptions:

Include when the group purchases benefits for clinical trials.

- [Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.]
- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for

that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

Include if extended dependent coverage requires Full-time Student status.

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

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

[1]Select option per group choice and delete others.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student [[1]at the end of the calendar month during which][[1]at the end of the calendar year during which][[1]on the date] you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

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

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

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

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

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

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

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

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

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

Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

[1]Include when Benefits are provided only for MH Services. [2]Include when Benefits are provided only for SUD Services. [3]Include when Benefits are provided for both MH and SUD Services.

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

Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

[1]Include when Benefits are provided only for MH Services. [2]Include when Benefits are provided only for SUD Services. [3]Include when Benefits are provided for both MH and SUD Services.

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

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

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

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

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

Include definition of Late Enrollee if it has also been included in Section 2 and Section 3.

[**Late Enrollee** - an Eligible Person or Dependent who enrolls for coverage under the Policy at a time other than the following:

- During the Initial Enrollment Period.
- During an Open Enrollment Period.
- During a special enrollment period as described in *Section 3: When Coverage Begins*.
- Within 31 days of the date a new Eligible Person first becomes eligible.]

Low Protein Modified Food Product - a food product specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an Inherited Metabolic Disease under the direction of a Physician

Include when group purchases benefits for manipulative treatment.

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

Maximum Policy Benefit - for Benefit plans that have a Maximum Policy Benefit, this is the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Policy issued to the Enrolling Group. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to a Maximum Policy Benefit and for details about how the Maximum Policy Benefit applies.

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

Include when group purchases MH (including Neurobiological Disorders) coverage.

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

Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

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

Include when group purchases MH (including Neurobiological Disorders) coverage.

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

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

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services [[1]by way of their participation in the [Shared Savings Program]]. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

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

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

Include when Open Enrollment is provided.

[Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.]

Orthotic Device - an external device that is, (i) intended to restore physiological function or cosmesis to a Covered Person; and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the Covered Person using the device prior to concurrent with the delivery of the device to the Covered Person.

Orthotic Service - the evaluation and treatment of a condition that requires the use of an Orthotic Device.

Prosthetic Device - an external device that is (i) intended to replace an external body part for the purpose of restoring physiological function or cosmesis to a patient; and (ii) custom designed, fabricated, assembled, fitted, or adjusted for patient using the device prior to or concurrent with being delivered to the Covered Person.

Prosthetic Service - the evaluation and treatment of a condition that requires the use of a Prosthetic Device.

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

Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

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

Include only when a per occurrence deductible applies.

[Per Occurrence Deductible - for Benefit plans that have a Per Occurrence Deductible, this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

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

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

Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of a Per Occurrence Deductible and for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.]

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

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

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy*.
- This *Certificate*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

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

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Include definition if group has purchased a preexisting condition exclusion. [1]Select the appropriate "look back period."

[Preexisting Condition - an Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the [[1]three] [[1]six] month period ending on the person's enrollment date. (The enrollment date is the date the person became covered under the Policy or, if earlier, the first day of any waiting period under the Policy.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.]

Pregnancy - includes all of the following:

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

Include when benefit for Infertility Services is sold.

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

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

[1]Include when group purchases MH (including Neurobiological Disorders) or SUD coverage and all clinicians are considered primary physicians. [5]Include when clinicians providing psychological testing are not considered specialists. Delete #1 entirely when all clinicians are considered specialists.

[2]Include when group purchases MH benefits. [3]Include when group purchases SUD benefits. [4]Include when group purchases both MH and SUD benefits.

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

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

[1]Include when Benefits are provided only for MH Services. [2]Include when Benefits are provided only for SUD Services. [3]Include when Benefits are provided for both MH and SUD Services.

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

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

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

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

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

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. The Shared Savings Program provision will not apply to Choice.

[[1][Shared Savings Program] - the [Shared Savings Program] provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the [Shared Savings Program] to pay claims when doing so will lower Eligible Expenses. We do not credential the [Shared Savings Program] providers and the [Shared Savings Program] providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by [Shared Savings Program] providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the [Shared Saving Program] to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.]

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

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

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

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

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

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

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

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

Include when group purchases SUD benefits.

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

Include when Enrolling Group purchases extended coverage and when the corresponding provision has been retained in Section 4.

[Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.]

Include when group purchases MH (including Neurobiological Disorders) and SUD coverage.

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

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

Include when group purchases MH (including Neurobiological Disorders) but not SUD coverage.

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

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

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

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

Please note:

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

- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - If the service is one that requires review by the *U.S. Food and Drug Administration (FDA)*, it must be *FDA*-approved.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
  - At least two studies must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
  - The service must be available from a Network Physician and/or a Network facility.

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

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

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

[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.

You can choose to receive [[1]Designated 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.]

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

[2]Include and delete #1if 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.]

[2]Include 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. [[2]Covered 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.]

[1]Always 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 [[1]through 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 [[1]when 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 [[1]over $[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 [[1]over $[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.]

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

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

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

- Orthotics devices [[1]over$[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.]

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

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

[1]Include 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. [1]Include when Manipulative Treatment is included in the rehabilitation services benefit.

- [Rehabilitation services [[1]and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [[1]Manipulative 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, [[1]Mental Illness,] [[2]mental 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. [1]Include when MH benefits are sold. [2]Include when SUD benefits are sold. [3]Include when both MH and SUD benefits are sold. [1-A]Include when benefits for Neurobiological Disorders - Autism Spectrum Disorders are sold.

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

[[[1]Mental Health Services [[1-A](including psychiatric services for Autism Spectrum Disorders)]] [[3]and] [[2]Substance 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 [[1]Mental Health Services] [[3]or] [[2]Substance 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 Coordination[SM]

When we are notified as required, we will work with you to implement the Care Coordination[SM] 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 [[1]Designated 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]Include when the Annual Deductible applies only to Non-	*[1]Include separate Network and Non-*

Network Benefits.

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

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

[4]Include when an Outpatient Prescription Drug Rider is sold and when the Annual Deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the Annual Deductible.

[5]Include 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.

[6]Include 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 [[1]Non-Network] Benefits. [[2]The 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*. [[3]Benefits for Outpatient Prescription Drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [[4]Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the *Outpatient Prescription Drug Rider* are not subject to payment of the Annual Deductible.] [[5]The Annual Deductible for [[6]Designated 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.

[2]Include 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. [1]Include 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. [[1]This 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).

	[$[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.]
Include only when a per occurrence deductible applies. **[Per Occurrence Deductible]**	
[The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.]	*[1]Include when Designated Network Benefits apply to either category.* ***[[[1]Designated Network and] Network]*** *Include when a per occurrence deductible applies to CHD surgery benefits.* [CHD surgery - Inpatient Stay: [$100 - 1,000] per day.] [CHD surgery - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to inpatient hospital benefits.* [Hospital - Inpatient Stay: [$100 - 1,000] per day.] [Hospital - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to outpatient surgery benefits.* [Surgery - Outpatient: [$10 - 1,000] per date of service.] *Include when a per occurrence deductible applies to inpatient transplant benefits.* [Transplant - Inpatient Stay: [$100 - 1,000] per day.] [Transplant - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] ***[Non-Network]*** *Include when a per occurrence deductible applies to CHD surgery benefits.* [CHD surgery - Inpatient Stay: [$100 - 1,000] per day.] [CHD surgery - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to inpatient hospital*

	benefits. [Hospital - Inpatient Stay: [$100 - 1,000] per day.] [Hospital - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to outpatient surgery benefits.* [Surgery - Outpatient: [$50 - 800] per date of service.] *Include when a per occurrence deductible applies to inpatient transplant benefits.* [Transplant - Inpatient Stay: [$100 - 1,000] per day.] [Transplant - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.]
Out-of-Pocket Maximum	

[1]Include when OOPM includes the Annual Deductible.

[2]Include when OOPM includes the Per Occurrence Deductible.

[3]Include when OOPM includes Copayments.

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

[5]Include 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.

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

The maximum you pay per year for [[1]the Annual Deductible,] [[2]the Per Occurrence Deductible,] [[3]Copayments] [[1-2-3]or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [[4]The 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*.] [[5]The Out-of-Pocket Maximum for [[6]Designated 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*.]

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

[[7]Copayments 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

[1]Include 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.

[2]Include 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

sold and Copayments/Coinsurance do not apply to the overall OOPM. • [Copayments or Coinsurance for Covered Health Services provided under the *Outpatient Prescription Drug Rider*.]	include the Per Occurrence Deductible.] *Include when there is no OOPM.* [No Out-of-Pocket Maximum.] ***[[1]Non-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 include the Per Occurrence Deductible.] *Include when there is no OOPM.* [No Out-of-Pocket Maximum.] *[3]Include combined Network and Non-Network heading and statements below*

	when OOPM provision applies 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.* ***[[3][2]Designated Network,] Network and Non-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 include the Per Occurrence Deductible.]

	Include when there is no OOPM. [No Out-of-Pocket Maximum.]
Maximum Policy Benefit	
The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Policy.	*[1]Include when separate Network and Non-Network Maximums apply.* *[2]Include when Designated Network Benefits apply to any category.* ***[[1][2]Designated Network and] Network]*** [$[1,000,000 - 10,000,000] per Covered Person.] [No Maximum Policy Benefit.] ***[[1]Non-Network]*** [$[1,000,000 - 10,000,000] per Covered Person.] [No Maximum Policy Benefit.] *[3]Include when combined Network and Non-Network Maximums applies.* ***[[3][2]Designated Network,] Network and Non-Network]*** [$[1,000,000 - 10,000,000] per Covered Person.]
Include only when an annual maximum benefit applies. **[Annual Maximum Benefit]**	

[The maximum amount we will pay for Benefits during the year.]	*[1]Include when separate Network and Non-Network Maximums apply.* *[2]Include when Designated Network Benefits apply to any category.* ***[[1][2]Designated Network and] Network]*** [$[2,000 - 500,000] per Covered Person.] ***[[1]Non-Network]*** [$[2,000 - 500,000] per Covered Person.] *[3]Include when combined Network and Non-Network Maximums applies.* ***[[3][2]Designated Network,] Network and Non-Network]*** [$[2,000 - 500,000] per Covered Person.]
Copayment	
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. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Benefit Limits

Include when benefit plan design has no additional limits.

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

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

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

Include when orthopedic surgery is limited.

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

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

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

- [Benefits for Covered Health Services for orthopedic surgery for joint replacement are limited to [[1]a 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] [[3]a 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 [[1]a 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] [[3]a 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?**
Include for groups that purchase benefits for acupuncture services. **1. [Acupuncture Services]**			
Include the limit selected by the group. [Limited to [10 - 100] visits per year.] [Limited to [10 - 100] visits per year, not to exceed $[100 - 5,000] in Eligible Expenses per year.] [Limited to $[100 - $5,000] in Eligible Expenses per year.] [This limit applies to Network Benefits only. Non-Network Benefits are not available.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available.]
[2.] Ambulance Services			
Pre-service Notification Requirement 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.			
Emergency Ambulance	***Network***		

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?**
Include the limit selected by the group. [Ground ambulance limited to $[500 - 5,000] per year.]	*Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 - 1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]	[Yes] [No]	[Yes] [No]
Include the limit selected by the group. [Air ambulance limited to $[1,000 - 10,000] per year.]	*Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] [100% after you pay a Copayment of $[2,500 - 10,000] per day] [100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]]	[Yes] [No]	[Yes] [No]
	Non-Network Same as Network	Same as Network	Same as Network
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	***Network*** *Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 -	[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?**
	1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]] *Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] [100% after you pay a Copayment of $[2,500 - 10,000] per day] [100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]] ***Non-Network*** Same as Network	[Yes] [No] Same as Network	[Yes] [No] Same as Network
Include for groups that purchase benefits for clinical trials. **[3.] [Clinical Trials]**			
When Clinical Trials benefit is included, pre-service notification requirement will always apply. **[Pre-service Notification Requirement]** [You must notify us as soon as the possibility of participation in a clinical trial arises. If you don't notify us, you will be responsible for paying all charges and no Benefits will be paid.]			
[Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*. Benefits are available when the Covered Health Services are provided by either Network or non-Network	***[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 *Schedule of Benefits*.] ***[Non-Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each		

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?**
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.)]	Covered Health Service category in this *Schedule of Benefits*.]		
Include for groups that purchase benefits for congenital heart disease services. **[4.] [Congenital Heart Disease Surgeries]**			
Include if pre-service notification is required. *[1]Include if Non-Network Benefits are sold and if use of a Designated Facility is required in order to receive Network Benefits.* **[Pre-service Notification Requirement]** [For Designated Network Benefits you must notify us as soon as the possibility of a Congenital Heart Disease (CHD) surgery arises. If you do not notify us and if, as a result, the CHD services are not performed at a Designated Network Facility, Designated Network Benefits will not be paid.] [[1]Non-Network Benefits will apply.]] *Include when notification is required.* *[1]Include applicable reduction in Benefits.* [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 [[1]50 - 95]% of Eligible Expenses].			
Include when Designated Network Benefits are available. [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.] *Include when CHD benefits are sold and when both Network and Non-Network Benefits are available.* [Network and Non-Network Benefits	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 -	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

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?**
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 *Schedule of Benefits*.]	1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]		
Include when use of a Designated Facility is required in order to receive Network Benefits. [For Network Benefits, CHD surgeries must be received at a Designated Facility. 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. 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 *Schedule of Benefits*.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
Include when Network and Non-Network Benefits are limited and insert the limit selected by the group. [Network and Non-Network Benefits are limited to $[30,000 - 250,000] per CHD surgery.] *Include when Non-Network Benefits are limited and insert the limit selected by the group.* [Non-Network Benefits are limited to	***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

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?**
$[30,000 - 250,000] per CHD surgery.]	Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]		
Include for groups that purchase benefits for accident-related dental services. **[5.] [Dental Services - Accident Only]**			
Include when pre-service notification is required. *[1]Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [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, [[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.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] ***[Non-Network]*** [Same as Network]	[Yes] [No] [Same as Network]	[Yes] [No] [Same as Network]
[6.] Diabetes 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?

[1]Include when the durable medical equipment benefit is sold.

[2]Include when the durable medical equipment benefit is not sold.

[3]Include when notification applies only to equipment that exceeds a minimum dollar amount and insert applicable dollar amount.

[4]Include applicable reduction in Benefits or no Benefits.

Pre-service Notification Requirement

For Non-Network Benefits you must notify us before obtaining any [[1]Durable Medical Equipment] [[2]diabetes equipment] for the management and treatment of diabetes [[3]that 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, [[4]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[4]you will be responsible for paying all charges and no Benefits will be paid].

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	***Network*** 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 *Schedule of Benefits*. ***Non-Network*** 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 *Schedule of Benefits*.
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment*. *Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.* [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-	***Network*** *[1]Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.* [[1]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*.] *[2]Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold.* *[3]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[4]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[2]For diabetes equipment, Benefits will be the same as those

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].]	stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [[3]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[4]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[5]Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold.* *[6]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[7]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[5]For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [[6]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[7]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[8]Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold.* *[9]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[10]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[8]For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [[9]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[10]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] ***Non-Network*** *[1]Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.* [[1]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*.] *[2]Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold.* *[3]Include when sold with a plan that has an annual deductible*		

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?**
	and select either "are" or "are not." *[4]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[2]For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [[3]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[4]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[5]Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold.* *[6]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[7]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[5]For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [[6]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[7]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[8]Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold.* *[9]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[10]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[8]For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [[9]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[10]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		

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?**
Include for groups that purchase benefits for DME. **[7.] [Durable Medical Equipment]**			
[1]Include when notification applies only to DME that exceeds 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 any Durable Medical Equipment [[1]that 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, [[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].]			
Include the limit selected by the group. *[1]Include either option as standard plan design.* [[1]Limited to $[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].] [[1]Limited per year as follows: • [$[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.] 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].] *[1]Include when Benefits are provided for speech aid and tracheo-*	***[Network]*** [[50 - 100]%]	[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?**
esophageal voice devices. *[2]Include when devices are not included in the annual DME limit.* [[1]Benefits 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 [[2]not] included in the annual limits stated above.] *Always include when the DME benefit is sold.* [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.]	***[Non-Network]*** [[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?**
Include when benefit is limited. [Limited to $[100 - 5,000] per year.] **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. *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.)* [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: • [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.] • [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and*	***Network*** [[50 - 100]%] *Include bracketed provision and select either #1 or #2 if the Copayment is waived.* *[1]Include as standard; [2]Include only to match prior benefit plans.* [100% after you pay a Copayment of $[5 - 500] per visit. [If you are admitted as an inpatient to a Network Hospital [[1]directly from the Emergency room] [[2]within 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.]] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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] *Include for 2-tiered Copayment option.*	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
Nuclear Medicine - Outpatient.] • [Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.] • [Outpatient surgery procedures described under *Surgery - Outpatient*.] • [Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.] *[1]Include bracketed reference to Manipulative treatment when Manipulative treatment benefits are sold.* • [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [*[1]and *Manipulative Treatment]*.]]	[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] *Include for 3-tiered Copayment option.* [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] *Include for 4-tiered Copayment option.* [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]		

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?**
	Include if plan design includes retrospective review of emergency services. [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] ***Non-Network*** Same as Network	Same as Network	Same as Network
Include as standard for groups of 2 to 15 and 15+. **[9.] Hearing Aids**			
Include the limit selected by the group. *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.* [Limited to $[2,800 - 5,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[three-five] years].] No Copayment, Coinsurance or Deductible will be applicable to Network or non-Network Hearing Aid Coverage.	***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[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?**
[10.] Home Health Care			
Include if pre-service notification is required. *[1]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For Non-Network Benefits 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.]			
Include the limit selected by the group. [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.] [Network Benefits are limited to [40 - 200] visits per year and Non-Network Benefits are limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.] *Include when infusion administration only is not included in the limit.* [This visit limit does not include any service which is billed only for the administration of intravenous infusion.]	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[11.] Hospice Care			

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?**
Include if pre-service notification is required. *[1]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [In addition, for Non-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]			
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per day] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per day]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[12.] Hospital - Inpatient Stay			

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?
Include when Benefit Activation Program is sold. *[1]Include applicable Benefit level.* **[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 [[1]50 - 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 *Customer Care* at the telephone number on your ID card.] *[1]Include applicable Benefit level.* **Pre-service Notification Requirement** 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 [[1]50 - 95]% of Eligible Expenses. *Include if pre-admission notification is required.* [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).]			
[1]Include heading and row when Designated Network Benefits apply. *Include when enhanced benefits apply to specific inpatient services.* *[2]Include when Physician's fees are paid under the facility charge.* [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:] • [The Copayment you pay for the facility charge [[2]and 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	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

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?**
the facility charge [[2]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].] [You can determine the specific surgical procedures or diagnoses 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.]	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

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]		
Include for groups that purchase infertility benefits. **[13]. [Infertility Services]**			
When this benefit is purchased, pre-service notification will always be required. [1]Include applicable reduction in Benefits or no Benefits. **[Pre-service Notification Requirement]** [You must notify us as soon as the possibility of the need for Infertility Services arises. If you fail to notify us as required, [[1]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[1]you will be responsible for paying all charges and no Benefits will be paid].]			
[1]Include heading and row when Designated Network Benefits apply.	***[[1]Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
Include the limit selected by the group. *[1]Include when the maximum benefit is combined with infertility drugs under the RX rider.* [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. [[1]This limit includes Benefits for infertility medications provided under the *Outpatient Prescription Drug Rider*.] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.]	***[Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Non-Network] [[50 - 100]%] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]

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			
Include when pre-service notification is required for sleep studies. *[1]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.]			
[1]Include heading and row when Designated Network Benefits apply. *Include limit selected by group.* [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 $[5 - 100] per service]	[Yes] [No]	[Yes] [No]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service]	[Yes] [No]	[Yes] [No]
	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			

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?**
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 [[1]50 - 95]% of Eligible Expenses.]			
[1]Include heading and row when Designated Network Benefits apply. *Include limit selected by group.* [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]	[Yes] [No]	[Yes] [No]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[25 - 500] per service]	[Yes] [No]	[Yes] [No]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[25 - 500] per service]	[Yes] [No]	[Yes] [No]
Include for groups that purchase Mental Health benefits. *[Include as standard for groups of 2 to 15]* *[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.* *[2]Include applicable reduction in Benefits.* *[3]Include as standard when parity does not apply.*			

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?**
[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 exempt from Parity requirements. Include the limit selected by the group.* *When parity does not apply, this first set of separate benefit statements and limits can be used. When parity does apply, delete these benefit and limit statements and use the "Depending upon" provisions further below."*	***[Network]*** *[Inpatient/Intermediate]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No]
Select from these limit options when limits apply only to Mental Health Services described in this section. [Inpatient/Intermediate *Mental Health Services* are limited to [10 - 100] days per year.] [Outpatient *Mental Health Services* are limited to [10 - 100] visits per year.] [Non-Network Benefits for Inpatient/Intermediate *Mental Health Services* are limited to [10 - 100] days per year.] [Non-Network Benefits for outpatient *Mental Health Services* are limited to [10 - 100] visits per year.] *Select from these limit options when limits apply to Mental Health Services described in this section combined*	*[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] ***[Non-Network]*** *[Inpatient/Intermediate]* [[50 - 100]%] [100% after you pay a Copayment of $[100 -	[Yes] [No] [Yes] [No]	[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?**
with Neurobiological Disorders - Autism Spectrum Disorders below. [Benefits for any combination of *Mental Health Services* described in this section and *Neurobiological Disorders - Autism Spectrum Disorders* described below are limited as follows: • [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*.]	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]		
Select from these limit options when limits apply to Mental Health Services described in this section combined with Substance Use Disorder Services below. [Benefits for any combination of *Mental Health Services* described in this section and *Substance Use Disorder Services* described below are limited as follows: • [10 - 100] days per year for Inpatient/Intermediate *Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Mental Health Services* and *Substance Use Disorder Services*.]	*[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]	[Yes] [No]	[Yes] [No]
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.*	***[Network]*** [Depending upon where the Covered Health Service is provided, Benefits for outpatient *Mental Health Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate		

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?**
	Mental Health Services will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
	[Non-Network] [Depending upon where the Covered Health Service is provided, Benefits for outpatient *Mental Health Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate *Mental Health Services* will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
Include for groups that purchase mental health benefits. . **[17.] [Neurobiological Disorders - Autism Spectrum Disorder Services]**			
When this benefit is purchased, prior authorization will always be required. [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 exempt from Parity requirements.*	***[Network]*** *[Inpatient/Intermediate]* [[50 - 100]%] [100% after you pay a	[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?**
Include the limit selected by the group. *When parity does not apply, this first set of separate benefit statements and limits can be used. When parity does apply, delete these benefit and limit statements and use the "Depending upon" provisions further below."*	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]		
Select from these limit options when limits apply only to Neurobiological Disorders - Autism Spectrum Disorders described in this section. [Inpatient/Intermediate *Neurobiological Disorders -Autism Spectrum Disorders* are limited to [10 - 100] days per year.] [Outpatient *Neurobiological Disorders - Autism Spectrum Disorders* are limited to [10 - 100] visits per year.] [Non-Network Benefits for Inpatient/Intermediate *Neurobiological Disorders -Autism Spectrum Disorders* are limited to [10 - 100] days per year.] [Non-Network Benefits for outpatient *Neurobiological Disorders -Autism Spectrum Disorders* are limited to [10 - 100] visits per year.] *Select from these limit options when limits apply to Neurobiological Disorders - Autism Spectrum Disorders described in this section combined with Mental Health Services above.* [Benefits for any combination of *Neurobiological Disorders - Autism Spectrum Disorders* described in this section and *Mental Health Services* described above are limited as follows:	*[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] ***[Non-Network]*** *[Inpatient/Intermediate]* [[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	[Yes] [No] [Yes] [No]	[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?**
• [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*.]	maximum Copayment of $[100 - 5,000] per Inpatient Stay]		
	[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]	[Yes] [No]	[Yes] [No]
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.*	***[Network]*** [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*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
	[Non-Network] [Depending upon where the Covered Health Service is provided, Benefits for outpatient *Neurobiological Services - Autism Spectrum Disorder Services* will be the same as those		

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?**
	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*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
Include for groups that purchase benefits for obesity surgery. **[18.] [Obesity Surgery]**			
When this benefit is purchased, pre-service notification will always be required. [1]*Include applicable Benefit level.* **[Pre-service Notification Requirement]** [You must notify us [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [In addition, for Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.] **[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]**			
[1]*Include heading and row when Designated Network Benefits apply.* [2]*Include when Designated Network Benefits apply.* [3]*Include when Network Benefits are available.* [4]*Insert the limit selected by the group.* [Any combination of [[2]Designated Network Benefits] [[3], Network Benefits] and Non-Network Benefits is limited to $[[4]50,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy. Non-Network Benefits are further	***[[1]Designated Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		

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?**
limited to $[[4]5,000 - 30,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.] *Include when there is not a Network level of benefits available.* [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.]	***[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 *Schedule of Benefits*.] ***[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 *Schedule of Benefits*.]		
Include if group purchases benefits for ostomy supplies. **[19.] [Ostomy Supplies]**			
Include the limit selected by the group. [Limited to $[500 - 25,000] per year.]	***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[20.] Pharmaceutical Products - 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?**
Include when notification is required for IV infusions. *[1]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.] *Include when notification is required for select Pharmaceutical Products.* [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 [[1]50 - 95]% of Eligible Expenses. 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.]			
[1]Include heading and row when Designated Network Benefits apply. *Include limit selected by group.* [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 $[5 - 100] per Pharmaceutical Product] *Include when Coinsurance is tiered and select the appropriate number of tiers by plan design.* [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]	[Yes] [No] [Yes, except when provided during a Physician office visit]	[Yes] [No] [Yes, except when provided during a Physician office visit]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per	[Yes] [No] [Yes, except when provided during a	[Yes] [No] [Yes, except when provided during a Physician office

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?**
	Pharmaceutical Product] *Include when Coinsurance is tiered and select the appropriate number of tiers by plan design.* [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] *Include when Coinsurance is tiered and select the appropriate number of tiers by plan design.* [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]	Physician office visit] [Yes] [No] [Yes, except when provided during a Physician office visit]	visit] [Yes] [No] [Yes, except when provided during a Physician office visit]
[21.] Physician Fees for Surgical and Medical 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?**
Include when Benefit Activation Program is sold. *[1]Include applicable Benefit level.* **[Benefit Activation Notification Requirement]** [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 [[1]50 - 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 *Customer Care* at the telephone number on your ID card.]			
[1]Include heading and row when Designated Network Benefits apply. *Include when enhanced benefits apply to specific Physician services.* [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:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.]	***[[1]Designated Network]*** [[50 - 100]%]	[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?**
• [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] **[Enhanced Benefits:]** • [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].] [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.]			
[2]Include text if the plan design supports paying non-network benefits for a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist). [[2]Covered 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.] *[3]Include text if the plan design supports paying non-network benefits for a non-Network consulting Physician, assistant surgeon or surgical assistant.* [[3]Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical	***Network*** [50 - 100]%	[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?**
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.]	***Non-Network*** [50 - 100]%	[Yes] [No]	[Yes] [No]
[22.] Physician's Office Services - Sickness and Injury			

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?**
Include when Benefit Activation Program is sold. *[1]Include applicable Benefit level.* **[Benefit Activation Notification Requirement]** [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 [[1]50 - 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 *Customer Care* at the telephone number on your ID card.]			
Include if group chooses to limit benefit. [1]Insert limit selected by group. [Limited to [[1]2 - 10] visits per year.] *[1]Include heading and row when Designated Network Benefits apply.* *Include when enhanced benefits apply to specific physician office services.* [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:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.]	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [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] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
• [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] **[Enhanced Benefits:]** • [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].] [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.]	that year] [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] [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]		
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	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
subject to Coinsurance only.) [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: • [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.] • [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*.] • [Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.] • [Outpatient surgery procedures described under *Surgery - Outpatient*.] • [Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.] *[1]Include bracketed reference to Manipulative treatment when Manipulative treatment benefits are sold.* • [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment].*]]	per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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] [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] ***Non-Network***		

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]%] [100% after you pay a Copayment of $[5 - 100] per visit] [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] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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] [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	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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]		
[1]Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude. [2]If Maternity Services are excluded, Complications of Pregnancy must always be included. **[23.] Pregnancy - [[1]Maternity Services] [[2]Complications of Pregnancy only]**			

[1]Include when benefits are provided for maternity services. [2]Include applicable Benefit level.

[[1]Pre-service Notification Requirement]

[[1]For 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 [[2]50 - 95]% of Eligible Expenses.]

[3]Include when benefits are provided for complications of pregnancy only. [4]Include applicable Benefit level.

[[3]Pre-service Notification Requirement]

[[3]For 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 [[4]50 - 95]% of Eligible Expenses.]

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.

[1]Include when benefits are provided for maternity services.

[[1]Network]

[3]Include when an annual deductible applies to network benefits.

[4]Include when Network services in the Physician's office are subject to a Copayment.

[[1]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* [[3]except 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

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?**
	length of stay]. [[4]For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.] ***[[1]Non-Network]*** *[3]Include when an annual deductible applies to non-network benefits.* *[4]Include when Non-Network services in the Physician's office are subject to a Copayment.* [[1]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* [[3]except 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]. [[4]For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.] *[2]Include when benefits are provided for complications of pregnancy only.* ***[[2]Network]*** [[2]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[[2]Non-Network]*** [[2]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
[24.] Preventive Care Services			
Include when preventive care is limited and select the limit that applies. [Preventive care services are limited to $[100 - 1,000] per year.] **Physician office services** 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,	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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] [100% after you pay a	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
16 years, and 18 years. No Copayment, Coinsurance or deductible will be applicable to Network or non-Network children's immunizations.	Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [Non-Network Benefits are not available except for children under the age of 19.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available except for children under the age of 19.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available except for children under the age of 19.]
Lab, X-ray or other preventive tests:	***Network***		

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?**
No deductible will be applicable to Network or non-Network Prostate Cancer Screening.	[[50 - 100]%] [100% after you pay a 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 except for children under the age of 19.]	[Yes] [No] [Yes] [No] [Non-Network Benefits are not available except for children under the age of 19.]	[Yes] [No] [Yes] [No] [Non-Network Benefits are not available except for children under the age of 19.]
Include when group purchases benefits for prosthetic devices. Prosthetics are a mandated benefit in Arkansas. **[25.] Prosthetic Devices and Services**			
Include if notification is required. *[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.			

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?

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 [[1]50 - 95]% of Eligible Expenses.

Include if pre-admission notification is required.

[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).]

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 *Schedule of Benefits*.

Include when group does not purchase benefits for prosthetic devices.

[1]Include when sold with a plan that has an annual deductible and select either "are" or "are not."

[2]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."

[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [[1]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[2]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]

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 *Schedule of Benefits*.

Include when group does not purchase benefits for prosthetic devices. The Benefit level inserted here must be the same as the plan Coinsurance level.

[1]Include when sold with a plan that has an annual deductible and select either "are" or "are not."

[2]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."

[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [[1]and Benefits [are] [are not] subject to payment of

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?**
	the Annual Deductible]. [[2]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
Include entire section when rehabilitation services benefit is sold. *[1]Include when Manipulative Treatment benefits are sold.* **[27.] [Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment]]**			
Include when notification is required for any rehabilitation service. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.]			
Include when per therapy limits apply. *[1]Include when Manipulative Treatment benefits are sold.* *[2]Include when vision therapy benefits are sold.* [Limited per year as follows: • [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.	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
• [10-100] visits of post-cochlear implant aural therapy. • [[2][10-100] visits of vision therapy.]] *Include when combined therapy visit limits apply.* *[1]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.* *[2]Include when vision therapy benefits are sold.* [Any combination of physical therapy, occupational therapy, [[1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [[2]and vision therapy] is limited to [10 - 160] visits per year.] *Include when combined therapy dollar limits apply.* *[1]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.* *[2]Include when vision therapy benefits are sold.* [Any combination of physical therapy, occupational therapy, [[1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [[2]and vision therapy] is limited to $[750 - 12,000] per year.]	***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
Include when combined therapy visit limits apply separately to network benefits and to non-network benefits. *[1]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.* *[2]Include when vision therapy benefits are sold.* [Network Benefits for any combination of physical therapy, occupational therapy, [1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [2]and vision therapy] are limited to [10 - 160] visits per year.] [Non-Network Benefits for any combination of physical therapy, occupational therapy, [1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [2]and vision therapy] are limited to [10 - 160] visits per year.]			
[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
Include when notification is required for scopic procedures. *[1]Include applicable Benefit level.* **[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 [1]50 - 95]% of Eligible Expenses.]			
[1]Include heading and row when	***[1]Designated***		

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?**
Designated Network Benefits apply.	***Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	Network [50 - 100]%	[Yes] [No]	[Yes] [No]
	Non-Network [50 - 100]%	[Yes] [No]	[Yes] [No]
[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
[1]Include applicable Benefit level.			
Pre-service Notification Requirement 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 [[1]50 - 95]% of Eligible Expenses.			
Include if pre-admission notification is required.			
[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).]			
Include limit selected by group. [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.]	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] *Copayment option below identified as #1 to be tied only to either of the options #1 below with an Inpatient Stay maximum.* [[1]100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [[1]100% after you pay a Copayment of $[50 - 1,000] per day to a	[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?**
	maximum Copayment of $[50 - 5,000] per Inpatient Stay] *Variable #1 can be used only with options numbered #1 above.* [[1]If 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.] [No Copayment applies if you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility.] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] [100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 -	[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?**
	1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay]		
Include for groups that purchase substance use disorder benefits. *[Include as standard for groups of 2 to 15]* **[30.] Substance Use Disorder Services**			
When this benefit is purchased, prior authorization will always be required. *[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 exempt from Parity requirements. Include the limit selected by the group.* *When parity does not apply, this first set of separate benefit statements and limits can be used. When parity does apply, delete these benefit and limit statements and use the "Depending upon" provisions further below."*	***[Network]*** *[Inpatient/Intermediate]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No]
Select from these limit options when limits apply only to Substance Use Disorder Services described in this	*[Outpatient]* [[50 - 100]%]	[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?**
section. [Inpatient/Intermediate *Substance Use Disorder Services* are limited to [10 - 100] days per year.] [Outpatient *Substance Use Disorder Services* are limited to [10 - 100] visits per year.] [Non-Network Benefits for Inpatient/Intermediate *Substance Use Disorder Services* are limited to [10 - 100] days per year.] [Non-Network Benefits for outpatient *Substance Use Disorder Services* are limited to [10 - 100] visits per year.] *Select from these limit options when limits apply to Substance Use Disorder Services described in this section combined with Mental Health Services above.* [Benefits for any combination of *Substance Use Disorder Services* described in this section and *Mental Health Services* described above are limited as follows: • [10 - 100] days per year for Inpatient/Intermediate *Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Mental Health Services* and *Substance Use Disorder Services*.]	[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]		
	[Non-Network] *[Inpatient/Intermediate]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a	[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?**
	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]		
	[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]	[Yes] [No]	[Yes] [No]
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.*	***[Network]*** [Depending upon where the Covered Health Service is provided, Benefits for outpatient *Substance Use Disorder Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate *Substance Use Disorder Services* will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
	[Non-Network] [Depending upon where the Covered Health Service is provided, Benefits for outpatient *Substance Use Disorder Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate *Substance Use Disorder* Services will be		

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?**
	the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
[31.] Surgery - Outpatient			
Include when Benefit Activation Program is sold. *[1]Include applicable Benefit level.* **[Benefit Activation Notification Requirement]** [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 [[1]50 - 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 *Customer Care* at the telephone number on your ID card.] *Include when notification is required.* *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [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.]			
[1]Include heading and row when Designated Network Benefits apply. *Include provision below when enhanced benefits apply to specific outpatient surgical services.* *[2]Include when Physician's fees are paid under the facility charge.* [When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as follows:] • [The Copayment you pay for the facility charge [[2]and Physician's	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[10 - 1,000] per date of service] [100%after you pay a Copayment of $[10 - 1,000] per date of service, to a maximum Copayment of $[10 - 5,000] per year]]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

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?**
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 [[2]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].] [You can determine the specific surgical procedures 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.]	***Network*** [[50 - 100]%] [[100% after you pay a Copayment of $[10 - 1,000] per date of service] [100% after you pay a Copayment of $[10 - 1,000] per date of service, to a maximum Copayment of $[10 - 5,000] per year]]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[10 - 1,000] per date of service]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

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]]		
Include when group purchases TMJ benefit. **[32.] Temporomandibular Joint Services**			
When this benefit is purchased, pre-service notification will always be required. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions.]			
Include the limit selected by the group. [Limited to $[1,000 - 20,000] per year.]	***[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 *Schedule of Benefits*.] ***[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 *Schedule of Benefits*.]		
[33.] Therapeutic Treatments - 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?**
Include when notification is required. *[1]Include applicable Benefit level.*			
[Pre-service Notification Requirement] [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 [[1]50 - 95]% of Eligible Expenses.]			
[1]Include heading and row when Designated Network Benefits apply.	***[[1]Designated Network]***		
	[[50 - 100]%] [100% after you pay a Copayment of $[25 - 100] per treatment]	[Yes] [No]	[Yes] [No]
	Network		
	[[50 - 100]%] [100% after you pay a Copayment of $[25 - 100] per treatment]	[Yes] [No]	[Yes] [No]
	Non-Network		
	[[50 - 100]%] [100% after you pay a Copayment of $[25 - 100] per treatment]	[Yes] [No]	[Yes] [No]
[34.] Transplantation 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?
[1]Include if Non-Network Benefits are sold.			
Pre-service Notification Requirement			
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 result, the services are not performed at a Designated Facility, Network Benefits will not be paid. [[1]Non-Network Benefits will apply.]			
[2]Include applicable benefit reduction penalty.			
[[1]For Non-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 fail to notify us as required, Benefits will be reduced to [[2]50 - 95]% of Eligible Expenses.]			
Include if Non-Network Benefits are sold and pre-admission notification is required.			
[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).]			
For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits. *Include when Non-Network Benefits are limited and insert the limit selected by the group.* [Non-Network Benefits are limited to $[30,000 - 250,000] per transplant.]	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied] [Non-Network Benefits are not

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?**
	Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay] [Non-Network Benefits are not available.]		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?**
Include when urgent care services are limited and insert the limit selected by the group. [Limited to $[100 - 5,000] per year.] [Limited to [2 - 10] visits per year.] *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.)* [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: • [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.] • [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*.] • [Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.] • [Outpatient surgery procedures described under *Surgery - Outpatient*.] • [Outpatient therapeutic procedures described under *Therapeutic Treatments -*	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
Outpatient.] *[1]Include bracketed reference to Manipulative treatment when Manipulative treatment benefits are sold.* • [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [[1]*and *Manipulative Treatment]*.]]	***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]
Include when group purchases benefits for vision exams. **[36.] [Vision Examinations]**			
[Limited to [1 exam] [[2-3] exams] per year.] [Limited to [1 exam] [[2-3] exams]	***[Network]*** [[50 - 100]%]	[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?**
every [2 - 3] years.]	[100% after you pay a Copayment of [$5 - 75] per visit] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of [$5 - 75] per visit] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]
Include when group purchases benefits for wigs. **[37.] [Wigs]**			
Include the limit selected by the group. [Limited to $[100 - 1,000] per year.] [Limited to $[100 - 5,000] every [24 - 36] months.]	***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
Additional Benefits Required By Arkansas Law			
[38.] Dental Services - Anesthesia and Hospitalization			
Pre-service Notification Requirement Any applicable notification requirements will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.			
[1]Include heading and row when Designated Network Benefits apply.	***[[1]Designated Network]*** [Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] ***Network*** Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*. ***Non-Network***		

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 *Hospital - Inpatient Stay* in this *Schedule of Benefits*.		
[39.] In Vitro Fertilization Services			
[1]*Include applicable reduction in Benefits or no Benefits.*			
Pre-service Notification Requirement			
You must notify us as soon as the possibility of the need for in vitro fertilization arises. If you fail to notify us as required, [[1]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[1]you will be responsible for paying all charges and no Benefits will be paid].			
1Include heading and row when Designated Network Benefits apply	[[1]***Designated Network***]	[Yes] [No]	[Yes] [No]
	[50 - 100%]		
Limited to a lifetime maximum of $15,000.	***Network***		
	[50 - 100%]	[Yes] [No]	[Yes] [No]
	Non-Network		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]	[Non-Network Benefits are not available.]
[40.] Medical Foods			
	[1]*Include when group purchases the Outpatient Prescription Drug Rider.*	[Yes] [No]	[Yes] [No]
	Network		
	Depending upon where the Covered Health Service is provided, Benefits will be [50 - 100]% [[1]or as provided under the *Outpatient Prescription Drug Rider*].		
	Non-Network		
	Same as Network	Same as Network	Same as Network

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?**
Mandated offer in Arkansas. **[[41.] Musculoskeletal Disorders of the Face, Neck or Head]**			
[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 *Schedule of Benefits*.]			
	[[1]Designated Network] [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[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 *Schedule of Benefits*.] ***[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 *Schedule of Benefits*.]		
[[42.] Orthotic Devices and Services			
Include if notification is required. *[1]1Include 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 [[1]Designated 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, [[1]Mental Illness,] [[2]mental 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 [[1]Designated Network Benefits and] Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a [[1]Designated 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.

  - **[**[1]For 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.

  - **[**[2]Fee(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 [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.

[1]Always 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 [[1]through 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 [[1]when 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 [[1]over $[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 [[1]over $[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.]

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

- Hospital inpatient care - all scheduled admissions [[1]and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery] [[2]and 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 [[1]over$[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. [1]Include if notification applies only to prosthetics that exceed a specific dollar amount and insert appropriate dollar amount.

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

[1]Include 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. [1]Include when Manipulative Treatment is included in the rehabilitation services benefit.

- [Rehabilitation services [[1]and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [[1]Manipulative 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, [[1]Mental Illness,] [[2]mental 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. [1]Include when MH benefits are sold. [2]Include when SUD benefits are sold. [3]Include when both MH and SUD benefits are sold. [1-A]Include when benefits for Neurobiological Disorders - Autism Spectrum Disorders are sold.

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

[[[1]Mental Health Services [[1-A](including psychiatric services for Autism Spectrum Disorders)]] [[3]and] [[2]Substance 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 [[1]Mental Health Services] [[3]or] [[2]Substance 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 Coordination[SM]]

[When we are notified as required, we will work with you to implement the Care Coordination[SM] 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	
[1]*Include when an Outpatient Prescription Drug Rider is sold and the Annual Deductible applies to any combination of medical and RX benefits.* [2]*Include when an Outpatient Prescription Drug Rider with separate Copayments for preventive medications is sold and the Annual Deductible does not apply to preventive medications.* [3]*Include when an Outpatient Prescription Drug Rider is sold and when the Annual Deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the Annual Deductible.* The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. [[1]The 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*. [[2]Benefits for Outpatient Prescription Drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [[3]Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the *Outpatient Prescription Drug Rider* are not subject to payment of the Annual Deductible.] *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*	*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.* [No Annual Deductible.]

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.* [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. [1]Include 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. [[1]This 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.]	
Include only when a per occurrence deductible applies. **[Per Occurrence Deductible]**	
[The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following:	*Include when a per occurrence deductible applies to CHD surgery benefits.* [CHD surgery - Inpatient Stay: [$100 - 1,000] per day.] [CHD surgery - Inpatient Stay: [$100 -

• The applicable Per Occurrence Deductible. • The Eligible Expense.]	2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to inpatient hospital benefits.* [Hospital - Inpatient Stay: [$100 - 1,000] per day.] [Hospital - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to outpatient surgery benefits.* [Surgery - Outpatient: [$10 - 1,000] per date of service.] *Include when a per occurrence deductible applies to inpatient transplant benefits.* [Transplant - Inpatient Stay: [$100 - 1,000] per day.] [Transplant - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.]
Out-of-Pocket Maximum	

[1]Include when OOPM includes the Annual Deductible. *[2]Include when OOPM includes the Per Occurrence Deductible.* *[3]Include when OOPM includes Copayments.* *[4]Include when an Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX* The maximum you pay per year for [[1]the Annual Deductible,] [[2]the Per Occurrence Deductible,] [[3]Copayments] [[1-2-3]or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [[4]The 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*.] *[5]Include only when the plan design does not apply all Copayments/Coinsurance to the OOPM.* [[5]Copayments 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 sold and Copayments/Coinsurance do not apply to the overall OOPM.* • [Copayments or Coinsurance for Covered Health Services provided under the *Outpatient Prescription Drug Rider*.]	*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 include the Per Occurrence Deductible.] *Include when there is no OOPM.* [No Out-of-Pocket Maximum.]
Maximum Policy Benefit	

The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Policy.	[$[1,000,000 - 10,000,000] per Covered Person.] [No Maximum Policy Benefit.]
Include only when an annual maximum benefit applies. **[Annual Maximum Benefit]**	
[The maximum amount we will pay for Benefits during the year.]	[$[2,000 - 500,000] per Covered Person.]

Copayment

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.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

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 [[1]a 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] [[3]a 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 [[1]a 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] [[3]a 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?
Include for groups that purchase benefits for acupuncture services. **1. [Acupuncture Services]**			
Include the limit selected by the group. [Limited to [10 - 100] visits per year.] [Limited to [10 - 100] visits per year, not to exceed $[100 - 5,000] in Eligible Expenses per year.] [Limited to $[100 - $5,000] in Eligible Expenses per year.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[2.] Ambulance Services			
Always include Pre-service Notification Requirement except when notification is not required for any service. **[Pre-service Notification Requirement]** [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.]			
Emergency Ambulance *Include the limit selected by the group.* [Ground ambulance limited to $[500 - 5,000] per year.]	*Ground Ambulance:* [50 - 100]%	[Yes] [No]	[Yes] [No]
Include the limit selected by the group. [Air ambulance limited to $[1,000 - 10,000] per year.]	*Air Ambulance:* [50 - 100]%	[Yes] [No]	[Yes] [No]
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	*Ground Ambulance:* [50 - 100]%	[Yes] [No]	[Yes] [No]
	Air Ambulance: [50 - 100]%	[Yes] [No]	[Yes] [No]
Include for groups that purchase benefits for clinical trials. **[3.] [Clinical Trials]**			
Always include Pre-service Notification Requirement except when notification is not required for any service. **[Pre-service Notification 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?
[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 *Schedule of Benefits*.	[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*.]		
Include for groups that purchase benefits for congenital heart disease services. **[4.] [Congenital Heart Disease Surgeries]**			
Include when notification is required. *[1]Include applicable reduction in 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 [[1]50 - 95]% of Eligible Expenses].			
Include when Benefits are limited and insert the limit selected by the group. [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]
Include for groups that purchase benefits for accident-related dental services. **[5.] [Dental Services - Accident Only]**			
Include when pre-service notification is required. *[1]Include applicable reduction in Benefits or no Benefits.* **[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			
Always include Pre-service Notification Requirement except when notification is not required for any service.			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[1]Include when the durable medical equipment benefit is sold. *[2]Include when the durable medical equipment benefit is not sold.* *[3]Include when notification applies only to equipment that exceeds a minimum dollar amount and insert applicable dollar amount.* *[4]Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [You must notify us before obtaining any [[1]Durable Medical Equipment] [[2]diabetes equipment] for the management and treatment of diabetes [[3]that 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, [[4]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[4]you will be responsible for paying all charges and no Benefits will be paid].]			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	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 *Schedule of Benefits*.		
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment*. *Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.* [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].]	*[1]Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.* [[1]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*.] *[2]Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold.* *[3]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[4]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[2]For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [[3]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[4]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[5]Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold.* *[6]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[7]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[5]For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [[6]and Benefits [are] [are not] subject to payment of		

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	the Annual Deductible]. [[7]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[8]Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold.* *[9]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[10]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[8]For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [[9]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[10]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
Include for groups that purchase benefits for DME. **[7.] [Durable Medical Equipment]**			
Always include Pre-service Notification Requirement except when notification is not required for any service. *[1]Include when notification applies only to DME that exceeds a minimum dollar amount and insert applicable dollar amount.* *[2]Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [You must notify us before obtaining any Durable Medical Equipment [[1]that 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, [[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].]			
Include the limit selected by the group. *[1]Include either option as standard plan design.* [[1]Limited to $[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].] [[1]Limited per year as follows: • [$[500 - 10,000] in Eligible Expenses for Tier 1.Tier 1 includes disposable supplies necessary for the effective use of covered Durable Medical	[[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?
Equipment.] • [$[10,001 - 25,000] in Eligible Expenses for Tier 2.] • [$[25,001 - 100,000] in Eligible Expenses for Tier 3.] 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].] *[1]Include when Benefits are provided for speech aid and tracheo-esophageal voice devices.* *[2]Include when devices are not included in the annual DME limit.* [[1]Benefits 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 [[2]not] included in the annual limits stated above.]			
[8.] Emergency Health Services - Outpatient			
Include when benefit is limited. [Limited to $[100 - 5,000] per year.]	[50 - 100]%	[Yes] [No]	[Yes] [No]
Include as standard for groups of 2 to 15 and 15+. **[9.] Hearing Aids**			
Include the limit selected by the group. *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.* [Limited to $[2,800 - 5,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [three-	[[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].] No Copayment, Coinsurance or Deductible will be applicable to Network or non-Network Hearing Aid Coverage.			
[10.] Home Health Care			
Include if pre-service notification is required. *[1]Include applicable reduction in Benefits.* **[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.]			
Include the limit selected by the group. [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.] *Include when infusion administration only is not included in the limit.* [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			
Include if pre-service notification is required. *[1]Include applicable reduction in Benefits.* **[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.] *Include if pre-admission notification is required.* [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			
Always include Pre-service Notification Requirement except when notification is not required for any			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
service. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [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).]			
	[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
Include for groups that purchase infertility benefits. **[13]. [Infertility Services]**			
Always include Pre-service Notification Requirement except when notification is not required for any service. *[1]Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [You must notify us as soon as the possibility of the need for Infertility Services arises. If you fail to notify us as required, [[1]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[1]you will be responsible for paying all charges and no Benefits will be paid].]			
Include the limit selected by the group. *[1]Include when the maximum benefit is combined with infertility drugs under the RX rider.* [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. [[1]This limit includes Benefits for infertility medications provided under the *Outpatient Prescription Drug Rider*.] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.]	[[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?
[14.] Lab, X-Ray and Diagnostics - Outpatient			
Include when pre-service notification is required for sleep studies. *[1]Include applicable reduction in Benefits.* **[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 [[1]50 - 95]% of Eligible Expenses.]			
Include limit selected by group. [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			
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]** [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 [[1]50 - 95]% of Eligible Expenses.]			
Include limit selected by group. [Limited to $[100 - 5,000] per year.]	[50 - 100]%	[Yes] [No]	[Yes] [No]
Include for groups that purchase Mental Health benefits. *[Include as standard for groups of 2 to 15]* *[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.* *[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,*	*[Inpatient/Intermediate]*		

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
limits are permitted only for small business (50 and fewer) or for non-ERISA groups that choose to be exempt from Parity requirements. Include the limit selected by the group. *When parity does not apply, this first set of separate benefit statements and limits can be used. When parity does apply, delete these benefit and limit statements and use the "Depending upon" provisions further below."*	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
Select from these limit options when limits apply only to Mental Health Services described in this section. [Inpatient/Intermediate *Mental Health Services* are limited to [10 - 100] days per year.] [Outpatient *Mental Health Services* are limited to [10 - 100] visits per year.] *Select from these limit options when limits apply to Mental Health Services described in this section combined with Neurobiological Disorders - Autism Spectrum Disorders below.* [Benefits for any combination of *Mental Health Services* described in this section and *Neurobiological Disorders - Autism Spectrum Disorders* described below are limited as follows: • [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*.] *Select from these limit options when limits apply to Mental Health Services described in this section combined with Substance Use Disorder Services below.*	*[Outpatient]* [[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?
[Benefits for any combination of *Mental Health Services* described in this section and *Substance Use Disorder Services* described below are limited as follows: • [10 - 100] days per year for Inpatient/Intermediate *Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Mental Health Services* and *Substance Use Disorder Services*.]			
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.*	[Depending upon where the Covered Health Service is provided, Benefits for outpatient *Mental Health Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate *Mental Health Services* will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
Include for groups that purchase mental health benefits. **[17.] [Neurobiological Disorders - Autism Spectrum Disorder Services]**			
When this benefit is purchased, prior authorization will always be required. [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 exempt from Parity requirements.*	*[Inpatient/Intermediate]* [[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?
Include the limit selected by the group. *When parity does not apply, this first set of separate benefit statements and limits can be used. When parity does apply, delete these benefit and limit statements and use the "Depending upon" provisions further below."*			
Select from these limit options when limits apply only to Neurobiological Disorders - Autism Spectrum Disorders described in this section. [Inpatient/Intermediate *Neurobiological Disorders -Autism Spectrum Disorders* are limited to [10 - 100] days per year.] [Outpatient *Neurobiological Disorders - Autism Spectrum Disorders* are limited to [10 - 100] visits per year.] *Select from these limit options when limits apply to Neurobiological Disorders - Autism Spectrum Disorders described in this section combined with Mental Health Services above.* [Benefits for any combination of *Neurobiological Disorders - Autism Spectrum Disorders* described in this section and *Mental Health Services* described above are limited as follows: • [10 - 100] days per year for Inpatient/Intermediate *Neurobiological Disorders - Autism Spectrum Disorders* and *Mental Health Services*. • [10 - 100] visits per year for outpatient *Neurobiological Disorders - Autism Spectrum Disorders* and *Mental Health Services*.]	*[Outpatient]* [[50 - 100]%]	[Yes] [No]	[Yes] [No]
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.*	[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*		

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.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
Include for groups that purchase benefits for obesity surgery. **[18.] [Obesity Surgery]**			
Always include Pre-service Notification Requirement except when notification is not required for any service. [1]*Include applicable Benefit level.* **[Pre-service Notification Requirement]** [You must notify us [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [In addition, you must contact us 24 hours before admission for an Inpatient Stay.] **[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.]**			
Include when group chooses to limit benefit. [1]*Insert the limit selected by the group.* [Limited to $[[1]50,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]	[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*.]		
Include if group purchases benefits for ostomy supplies. **[19.] [Ostomy Supplies]**			
Include the limit selected by the group. [Limited to $[500 - 25,000] per year.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[20.] Pharmaceutical Products - Outpatient			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Include when notification is required for IV infusions. *[1]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.] *Include when notification is required for select Pharmaceutical Products.* [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 [[1]50 - 95]% of Eligible Expenses. 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 limit selected by group. [Limited to $[100 - 5,000] per year.]	[[50 - 100]%] *Include when Coinsurance is tiered and select the appropriate number of tiers by plan design.* [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]	[Yes] [No] [Yes, except when provided during a Physician office visit]	[Yes] [No] [Yes, except when provided during a Physician office visit]
[21.] Physician Fees for Surgical and Medical Services			
	[50 - 100]%	[Yes] [No]	[Yes] [No]
[22.] Physician's Office Services - Sickness and Injury			
Include if group chooses to limit benefit. [1]Insert limit selected by group. • 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	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [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	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years. No Copayment, Coinsurance or deductible will be applicable to Network or Non-Network children's immunizations.	office visit] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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] [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]		
[1]Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude. [2]If Maternity Services are excluded, Complications of Pregnancy must always be included. **[23.] Pregnancy - [[1]Maternity Services] [[2]Complications of Pregnancy only]**			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Always include Pre-service Notification Requirement except when notification is not required for any service. *[1]Include when benefits are provided for maternity services.* *[2]Include applicable Benefit level.* **[[1]Pre-service Notification Requirement]** [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 [[2]50 - 95]% of Eligible Expenses.] *[3]Include when benefits are provided for complications of pregnancy only.* *[4]Include applicable Benefit level.* **[[4]Pre-service Notification Requirement]** [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 [[4]50 - 95]% of Eligible Expenses.] *Always include notification statement except when notification is not required for any service.* **[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.]**			
	[1]Include when benefits are provided for maternity services. *[3]Include when an annual deductible applies.* *[4]Include when services in the Physician's office are subject to a Copayment.* [[1]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* [[3]except 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]. [[4]For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.] *[2]Include when benefits are provided for complications of pregnancy only.* [[2]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
[24.] Preventive Care Services			
Include when preventive care is limited and select the limit that applies. [Preventive care services are limited to $[100 - 1,000] per year.]	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit]	[Yes] [No] [Yes, when Benefits are subject to	[Yes] [No] [Yes, when Benefits are subject to

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Physician office services [Limited to [2 - 10] visits per year.] • Well baby and well child care includes, but not limited to, 20 visits at approximately the following age intervals: birth, two weeks, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, three years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years. No Copayment, Coinsurance or Deductible will be applicable to Network or Non-Network children's immunizations.	[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] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]	Coinsurance] [Yes] [No]	Coinsurance] [Yes] [No]
Lab, X-ray or other preventive tests: No deductible will be applicable to Prostate Cancer Screening.	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service]	[Yes] [No]	[Yes] [No]
Include when group purchases benefits for prosthetic devices. Prosthetics is a mandated benefit in Arkansas. **[25.] Prosthetic Devices and Services**			
Include if notification is required. *[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]** [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.	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[26.] Reconstructive Procedures			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Always include Pre-service Notification Requirement except when notification is not required for any service. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [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).]			
	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*. *Include when group does not purchase benefits for prosthetic devices.* *[1]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[2]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [[1]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[2]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
Include entire section when rehabilitation services benefit is sold. *[1]Include when Manipulative Treatment benefits are sold.* **[27.] [Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment]]**			
Include when notification is required for any rehabilitation service. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.]			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Include when per therapy limits apply. *[1]Include when Manipulative Treatment benefits are sold.* *[2]Include when vision therapy benefits are sold.* [Limited per year as follows: • [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.]] *Include when combined therapy visit limits apply.* *[1]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.* *[2]Include when vision therapy benefits are sold.* [Any combination of physical therapy, occupational therapy, [[1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [[2]and vision therapy] is limited to [10 - 160] visits per year.] *Include when combined therapy dollar*	[[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?
limits apply. *[1]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.* *[2]Include when vision therapy benefits are sold.* [Any combination of physical therapy, occupational therapy, [[1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [[2]and vision therapy] is limited to $[750 - 12,000] per year.] Include when combined therapy visit limits apply separately to network benefits and to non-network benefits.			
[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
Include when notification is required for scopic procedures. *[1]Include applicable Benefit level.* **[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 [[1]50 - 95]% of Eligible Expenses.]			
	[50 - 100]%	[Yes] [No]	[Yes] [No]
[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Always include Pre-service Notification Requirement except when notification is not required for any service. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.]			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Include if pre-admission notification is required. [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).]			
Include limit selected by group. [Limited to [40 - 180] days per year.]	[50 - 100]%	[Yes] [No]	[Yes] [No]
Include for groups that purchase substance use disorder benefits. *[Include as standard for groups of 2 to 15]* ***[30.] Substance Use Disorder Services***			
When this benefit is purchased, prior authorization will always be required. *[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 exempt from Parity requirements. Include the limit selected by the group.* *When parity does not apply, this first set of separate benefit statements and limits can be used. When parity does apply, delete these benefit and limit statements and use the "Depending upon" provisions further below."*	*[Inpatient/Intermediate]* [[50 - 100]%]	[Yes] [No]	[Yes] [No]
Select from these limit options when limits apply only to Substance Use Disorder Services described in this section. [Inpatient/Intermediate *Substance Use Disorder Services* are limited to [10 - 100] days per year.] [Outpatient *Substance Use Disorder*	*[Outpatient]* [[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?
Services are limited to [10 - 100] visits per year.] *Select from these limit options when limits apply to Substance Use Disorder Services described in this section combined with Mental Health Services above.* [Benefits for any combination of *Substance Use Disorder Services* described in this section and *Mental Health Services* described above are limited as follows: • [10 - 100] days per year for Inpatient/Intermediate *Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Mental Health Services* and *Substance Use Disorder Services*.]			
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.*	[Depending upon where the Covered Health Service is provided, Benefits for outpatient *Substance Use Disorder Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate *Substance Use Disorder Services* will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
[31.] Surgery - Outpatient			
Include when notification is required. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [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 possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
	[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?
			[Yes, after the Per Occurrence Deductible is satisfied]
Include when group purchases TMJ benefit **[32.] [Temporomandibular Joint Services]**			

Always include Pre-service Notification Requirement except when notification is not required for any service.

[1]Include applicable Benefit level.

[Pre-service Notification Requirement]

[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 [[1]50 - 95]% of Eligible Expenses.]

Include if pre-admission notification is required.

[In addition, you must contact us 24 hours before admission for scheduled inpatient admissions.]

Include the limit selected by the group. [Limited to $[1,000 - 20,000] per year.]	[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]
[33.] Therapeutic Treatments - Outpatient	

Include when notification is required.

[1]Include applicable Benefit level.

[Pre-service Notification Requirement]

[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 [[1]50 - 95]% of Eligible Expenses.]

	[50 - 100]%	[Yes] [No]	[Yes] [No]
[34.] Transplantation Services			

Always include notification requirement except when notification is not required for any service.

[1]Include applicable Benefit level.

[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 [[1]50 - 95]% of Eligible Expenses.

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Include if pre-admission notification is required. [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).]			
	[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
[35.] Urgent Care Center Services			
Include when urgent care services are limited and insert the limit selected by the group. [Limited to $[100 - 5,000] per year.] [Limited to [2 - 10] visits per year.]	[50 - 100]%	[Yes] [No]	[Yes] [No]
Include when group purchases benefits for vision exams. **[36.] [Vision Examinations]**			
[Limited to [1 exam] [[2-3] exams] per year.] [Limited to [1 exam] [[2-3] exams] every [2 - 3] years.]	[[50 - 100]%] [100% after you pay a Copayment of [$5 - 75] per visit]	[Yes] [No]	[Yes] [No]
Include when group purchases benefits for wigs. **[37.] [Wigs]**			
Include the limit selected by the group. [Limited to $[100 - 1,000] per year.] [Limited to $[100 - 5,000] every [24 - 36] months.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
Additional Benefits Required By Arkansas Law			
[38.] Dental Services - Anesthesia and Hospitalization			
Always include Pre-service Notification Requirement except when notification is not required for any service. **[Pre-service Notification Requirement]** [Any applicable notification requirements will be the same as those stated under *Hospital - Inpatient Stay*			

in this *Schedule of Benefits*.]			
	Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.		
[39.] In Vitro Fertilization Services			
Always include Pre-service Notification Requirement except when notification is not required for any service. *[1]Include applicable Benefit level.* **[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			
	[1]Include when group purchases the Outpatient Prescription Drug Rider. Depending upon where the Covered Health Service is provided, Benefits will be [50 - 100]% [[1]or as provided under the *Outpatient Prescription Drug Rider*].	[Yes] [No]	[Yes] [No]
Mandated offer in Arkansas. **[[41.] Musculoskeletal Disorders of the Face, Neck or Head]**			
Always include Pre-service Notification Requirement except when notification is not required for any service. **[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 *Schedule of Benefits*.]			
[42.] Orthotic Devices and Services	[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*.]		
Include if notification is required. *[1]1Include 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 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

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.

[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, [[1]Mental Illness,] [[2]mental 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]:

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

- **[**[1]For 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, include the following and delete PHCS provisions.

- **[**[2]Fee(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.

UnitedHealthcare Insurance Company

[Catalyst] [Catalyst Choice] Rider

NOTE: This Rider supports both Catalyst and Catalyst Choice Products. Product names filed as variable to allow name change in future.

Include second sentence when Rider Benefits are available only to the Subscriber or only to Enrolled Dependents. Delete second sentence when Rider Benefits are available to all Covered Persons.

[1]Include when Rider Benefits are available only to the Subscriber.

[2]Include when Rider Benefits are available only to Enrolled Dependents.

This Rider to the Policy provides a limited amount of Benefits that you can access prior to meeting the Annual Deductible requirement stated in the *Schedule of Benefits*. [[Catalyst] [Catalyst Choice] Rider Benefits are available only to [[1]the Subscriber] [[2]Enrolled Dependents] and any reference to "you" in this Rider is a reference to [[1]the Subscriber] [[2]Enrolled Dependents].]

[Catalyst] [Catalyst Choice] Rider Benefits

[1]Include either calendar year or Policy year to match the underlying plan set-up.

[Catalyst] [Catalyst Choice] Rider Benefits are available to you on a [[1]calendar] [[1]Policy] year basis.

[2]Insert annual limit.

[3]Include when Rider Benefits apply to Designated Network Benefits. Include comma/or as needed.

[4]Include when Rider Benefits apply to Non-Network Benefits.

[5]Include and insert annual limit when all services are subject to an overall annual maximum and when first dollar benefits are limited both per person and per family. This option is available only when Rider Benefits are available to all Covered Persons.

[6]Include only when these services will have a separate annual maximum from other Rider benefits.

[7]Include when Preventive Care Services are included along with ambulance and emergency in the separate annual maximum.

We will pay $[[2]50 - 5,000] in [Catalyst] [Catalyst Choice] Benefits per Covered Person in a single year for Covered Health Services identified below that are received from a [[3]Designated Network] [,] [or] Network [[4]or non-Network] provider before you are responsible for meeting the Annual Deductible stated in the *Schedule of Benefits*. [[5]The total amount of [Catalyst] [Catalyst Choice] Rider Benefits is further limited to $[100 - 10,000] in a single year for all Covered Persons in a family.] [[6]**Ambulance Services** and **Emergency Health Services - Outpatient** [[7]and **Preventive Care Services**] are not included in this annual maximum, but are instead subject to a separate maximum. We will pay $[100 - 7,000] per Covered Person per year in [Catalyst] [Catalyst Choice] Rider Benefits for any combination of **Ambulance Services** and **Emergency Health Services - Outpatient** described below [[7]and we will pay [$50 - 5,000] per Covered Person per year in [Catalyst Choice] Rider Benefits for **Preventive Care Services**].]

After [Catalyst] [Catalyst Choice] Rider Benefits have been exhausted, you must then meet the Annual Deductible before we begin to pay Benefits as described in the *Schedule of Benefits*.

[8]Include when Copayments/Coinsurance are not applied toward the Annual Deductible.

The amount that you pay for [Catalyst] [Catalyst Choice] Rider Benefits in Copayments or Coinsurance will [[8]not] be applied toward the Annual Deductible stated in the *Schedule of Benefits.*

The amount that you pay for [Catalyst] [Catalyst Choice] Rider Benefits in Copayments will not be applied toward the Out-of-Pocket Maximum stated in the *Schedule of Benefits*; however Coinsurance paid for [Catalyst] [Catalyst Choice] Rider Benefits will be applied to the Out-of-Pocket Maximum.

If you meet the Out-of-Pocket Maximum stated in the *Schedule of Benefits* before reaching your [Catalyst] [Catalyst Choice] Rider Benefit limits, you will continue to pay Copayments or Coinsurance for [Catalyst] [Catalyst Choice] Rider Benefits.

[9]Include when Rider Benefits are not included in the maximum policy benefit.

[10]Include when the underlying medical plan has an annual maximum benefit and when Rider Benefits are not included in the annual maximum benefit.

[11]Include when the underlying medical plan has an annual maximum benefit and when Rider Benefits are included in the annual maximum benefit.

The amount that we pay for [Catalyst] [Catalyst Choice] Rider Benefits is [[9]not] included in any Maximum Policy Benefit [[10]or any Annual Maximum Benefit] [[11]and any Annual Maximum Benefit] stated in the *Schedule of Benefits.*

Benefits for Covered Health Services that are subject to day or visit limits as stated in the *Schedule of Benefits* are reduced by any days or visits paid as [Catalyst] [Catalyst Choice] Rider Benefits. Benefits for Covered Health Services that are subject to dollar limits as stated in the *Schedule of Benefits* are not reduced by any dollars paid as [Catalyst] [Catalyst Choice] Rider Benefits.

Covered Health Services to which [Catalyst] [Catalyst Choice] Rider Benefits apply are listed below and are described in *Section 1: Covered Health Services* of the *Certificate of Coverage.*

Include service categories and Benefit statements to support plan design.

[Ambulance Services]

[Emergency Ambulance]

[We will pay Benefits as stated in the *Schedule of Benefits* for either ground or air ambulance. Benefits for Emergency ambulance services by a non-Network provider are payable as Network Benefits.]

[Non-Emergency Ambulance]

[We will pay Benefits as stated in the *Schedule of Benefits* for either ground or air ambulance. Benefits for non-Emergency ambulance services by a non-Network provider are payable as Network Benefits.]

[Clinical Trials]

[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 Rider.]

[Congenital Heart Disease Surgeries]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Designated Network, Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Dental Services - Accident Only]

[We will pay Benefits as stated in the *Schedule of Benefits*. Benefits for services by a non-Network provider are payable as Network Benefits.]

[Diabetes Services]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Durable Medical Equipment]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Emergency Health Services - Outpatient]

[1]Include if plan design supports applying a Copayment or Coinsurance different from the underlying plan.

[2]Include if plan design supports applying a Copayment.

[3]Include if the Copayment will be waived if admitted directly from the ER.

[4]Include if plan design is based on the underlying plan.

[[[1]We will pay [50 - 100]% of Eligible Expenses [[2]after you pay a Copayment of $[5 - 300] per visit. [[3]If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.]] [[4]We will pay Benefits as stated in the *Schedule of Benefits*.] Benefits for Emergency Health Services by a non-Network provider are payable as Network Benefits.]

[Hearing Aids]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Home Health Care]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Hospice Care]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Hospital - Inpatient Stay]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Designated Network, Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Lab, X-Ray and Diagnostics - Outpatient]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Designated Network, Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Designated Network, Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Designated Network Benefits, we will pay 100% of Eligible Expenses after you pay a Copayment of $[25 - 500] per service.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay 100% of Eligible Expenses after you pay a Copayment of $[25 - 500] per service.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay 100% of Eligible Expenses after you pay a Copayment of $[25 - 500] per service.]

Note that for plans subject to Parity requirements, benefits for Mental Health Services must match those listed under Hospital - Inpatient Stay (for inpatient/intermediate) and Physician Office Services - Sickness and Injury (for outpatient).

[Mental Health Services]

[Inpatient/Intermediate:]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Outpatient:]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Network or Non-Network level of benefits supports applying a Copayment or Coinsurance different from the underlying plan. [3]Include if plan design supports applying a Copayment. [4]Include if plan design supports applying a split Copayment.

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]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].]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]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].]

Note that for plans subject to Parity requirements, benefits for Neurobiological Disorders - Autism Spectrum Disorders must match those listed under Hospital - Inpatient Stay (for inpatient/intermediate) and Physician Office Services - Sickness and Injury (for outpatient).

[Neurobiological Disorders - Autism Spectrum Disorders]

[Inpatient/Intermediate:]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Outpatient:]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Network or Non-Network level of benefits supports applying a Copayment or Coinsurance different from the underlying plan. [3]Include if plan design supports applying a Copayment. [4]Include if plan design supports applying a split Copayment.

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]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].]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]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].]

[Ostomy Supplies]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Pharmaceutical Products - Outpatient]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Designated Network, Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Physician Fees for Surgical and Medical Services]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Designated Network, Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Physician's Office Services - Sickness and Injury]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Designated Network, Network or Non-Network level of benefits supports applying a Copayment or Coinsurance different from the underlying plan. [3]Include if plan design supports applying a Copayment. [4]Include if plan design supports applying a split Copayment.

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]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].]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]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].]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]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].]

[5]Include when covered health services performed in a physician's office are subject to the copayments/coinsurance stated under other benefit categories, in addition to the office visit copayment stated in this section. (This will not apply when the office visit benefit is subject to coinsurance only.)

[[5]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:

- [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.]
- [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*.]
- [Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.]
- [Outpatient surgery procedures described under *Surgery - Outpatient*.]
- [Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.]

[1]Include bracketed reference to Manipulative Treatment when Manipulative Treatment benefits are sold.

- [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment]*.]]

[Pregnancy - Maternity Services]

[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 Rider.]

[Preventive Care Services]

[Physician office services]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Designated Network, Network or Non-Network level of benefits supports applying a Copayment or Coinsurance different from the underlying plan. [3]Include if plan design supports applying a Copayment. [4]Include if plan design supports applying a split Copayment.

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]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].]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]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].]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]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].]

[3]Include when non-network benefits for preventive care are not available under the underlying plan.

[[3]Non-Network Benefits are not available.]

[Lab, X-ray or other preventive tests]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Designated Network, Network or Non-Network level of benefits supports applying a Copayment or Coinsurance different from the underlying plan. [3]Include if plan design supports applying a Copayment.

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per service].]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per service].]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per service].]

[3]Include when non-network benefits for preventive care are not available under the underlying plan.

[[3]Non-Network Benefits are not available.]

[Prosthetic Devices]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Reconstructive Procedures]

[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 Rider.]

[1]Include if underlying plan provides Manipulative Treatment benefits.

[Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment]]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Designated Network, Network or Non-Network level of benefits supports applying a Copayment or Coinsurance different from the underlying plan. [3]Include if plan design supports applying a Copayment. [4]Include if plan design supports applying a split Copayment.

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]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].]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]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].]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]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].]

[Scopic Procedures - Outpatient Diagnostic and Therapeutic]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Designated Network, Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Skilled Nursing Facility/Inpatient Rehabilitation Facility Services]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

Note that for plans subject to Parity requirements, benefits for Substance Use Disorder Services must match those listed under Hospital - Inpatient Stay (for inpatient/intermediate) and Physician Office Services - Sickness and Injury (for outpatient).

[Substance Use Disorder Services]

[Inpatient/Intermediate:]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Outpatient:]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Network or Non-Network level of benefits supports applying a Copayment or Coinsurance different from the underlying plan. [3]Include if plan design supports applying a Copayment. [4]Include if plan design supports applying a split Copayment.

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]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].]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit] [[4]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].]

[Surgery - Outpatient]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Designated Network, Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Therapeutic Treatments - Outpatient]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Designated Network, Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Designated Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Designated Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Transplantation Services]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Network or Non-Network level of benefits supports applying a Coinsurance different from the underlying plan.

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses.]

[Urgent Care Center Services]

[1]Include when Rider Benefits apply only to Network Benefits and if plan design supports applying a Copayment or Coinsurance different from the underlying plan. [2]Include if plan design supports applying a Copayment.

[[1]We will pay [50 - 100]% of Eligible Expenses [[2]after you pay a Copayment of $[5 - 150] per visit].]

[3]Include when Rider Benefits apply to both Network and Non-Network Benefits and if plan design supports applying a Copayment or Coinsurance different from the underlying plan.

[[3]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[2]after you pay a Copayment of $[5 - 150] per visit]. For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[4]after you pay a Copayment of $[5 - 150] per visit].]

[4]Include when the plan design is based on the underlying plan.

[[4]We will pay Benefits as stated in the *Schedule of Benefits*.]

[5]Include when covered health services performed in 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 center benefit is subject to coinsurance only.)

[[5]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:

- [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.]
- [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*.]
- [Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.]
- [Outpatient surgery procedures described under *Surgery - Outpatient*.]
- [Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.]

[1]Include bracketed reference to Manipulative Treatment when Manipulative Treatment benefits are sold.

- [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment]*.]]

[Vision Examinations]

[1]Include when the plan design is based on the underlying plan.

[[1]We will pay Benefits as stated in the *Schedule of Benefits*.]

[2]Include as applicable when Plan design for any Network or Non-Network level of benefits supports applying a Copayment or Coinsurance different from the underlying plan. [3]Include if plan design supports applying a Copayment.

[[2]For Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit].]

[[2]For Non-Network Benefits, we will pay Benefits as stated in the *Schedule of Benefits*.]

[[2]For Non-Network Benefits, we will pay [50 - 100]% of Eligible Expenses [[3]after you pay a Copayment of $[5 - 75] per visit].]

[3]Include when non-network benefits for vision exams are not available under the underlying plan.

[[3]Non-Network Benefits are not available.]

[1]Include when first dollar benefits are limited both per person and per family. This option is available only when Rider Benefits are available to all Covered Persons.

[Catalyst] [Catalyst Choice] Rider Benefits apply only to the current year. If you [[1]or all Covered Persons in your family] do not use the total amount of [Catalyst] [Catalyst Choice] Rider Benefits available in a single year, the remaining amount of [Catalyst] [Catalyst Choice] Rider Benefits will not be carried over to the next year.

_____

(Name and Title)

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and in this Rider in *Section 3: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to [UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

Include only one of the three COB options listed below.

Include if COB does not apply to RX benefits.

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.]

Include if COB applies to RX benefits.

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the *Certificate*.]

Include if COB applies only to Medicare Part B and/or D. Include Part B, D or both option when applicable.

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider, except that Benefits for Prescription Drug Products will be coordinated with prescription drug benefits provided under Medicare [Part B] [Part D] [Parts B and D].]

_____

(Name and Title)

Introduction

Coverage Policies and Guidelines

[1]Include when notification is required.

[2]Include when prior authorization is required.

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or [[1]notification] [[2]prior authorization] requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others, therefore; a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

[1]Include only if the Copayment provision applies to this benefit design.

[2]Include only if the Annual Drug Deductible provision applies to this benefit design.

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost [[1], less the required Copayment] [[2], after the Annual Drug Deductible has been met].

Include the name and address of the appropriate Pharmacy Benefit Manager.

Submit your claim to:

[Name of Pharmacy Benefit Manager]

[Address of Pharmacy Benefit Manager]

[City, State and Zip Code]

Include for groups that purchase the designated pharmacy benefit. Designated pharmacy can be utilized for more than the specialty drug program. It applies to specialty when #1 below is included.

[1]Include when benefit plan design includes specialty drug program.

[Designated Pharmacies]

[If you require certain Prescription Drug Products [[1], including, but not limited to, Specialty Prescription Drug Products,] we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Prescription Drug Product.]

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

[1]Include if the Annual Drug Deductible applies. [2]Include only when plans pass rebates on to customers. [3]Include for all other plans. [4]Include only if the Copayment provision applies to this benefit design.

We may receive rebates for certain drugs included on the Prescription Drug List [[1], including those drugs that you purchase prior to meeting your Annual Drug Deductible]. We [[2]do] [[3]do not] pass these rebates on to you [[2], and they are] [[3], nor are they] [[1]applied to your Annual Drug Deductible] [[4]taken into account in determining your Copayments].

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Prescription Drug Rider. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug Rider. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication regimens. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

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Section 1: Benefits for Prescription Drug Products

[1]Include only if the Copayment provision applies to this benefit design.

[2]Include only if the Annual Drug Deductible provision applies to this benefit design.

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable [[1]Copayment and other payment] [[2]Annual Drug Deductible and other payment] requirements.

Contraceptives are mandated in AR, except for religious group employers. [1]Remove for religious employers who choose to exclude contraceptive coverage.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service[[1] or is prescribed to prevent conception].

Include when plan includes Specialty Drug Program.

[Specialty Prescription Drug Products]

[Benefits are provided for Specialty Prescription Drug Products.

[1]Include for groups that purchase Designated Pharmacy benefit.

[[1]If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Specialty Prescription Drug Product.]

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product [[1]and Designated Pharmacy].

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.]

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Prescription Drugs from a Retail Non-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail non-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with us, as described in *Section 5* of your *Certificate*. We will not reimburse you for the difference between the Predominant Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail non-Network Pharmacy supply limits.

Include for groups that purchase the mail order benefit option.

[Prescription Drug Products from a Mail Order Network Pharmacy]

[Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on mail order Network Pharmacy supply limits.

Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.]

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* apply also to this Rider, except that any preexisting condition exclusion in the *Certificate* is not applicable to this Rider. In addition, the exclusions listed below apply.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

[1]Remove only when Enrolling Group requests coverage for non-Emergency drugs dispensed outside the U.S.

[2.] [[1]Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.]

[3.] Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.

[4.] Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion will not apply to Prescription Drug Products approved by the *United States Food and Drug Administration (USFDA)* for use in the treatment of cancer on the basis that the Prescription Drug Product has not been approved by the *USFDA* for the treatment of the specific type of cancer for which the Prescription Drug Product has been prescribed, provided:

- the Prescription Drug Product has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one or more compendia:
  - the *American Hospital Formulary Service Drug Information*;
  - the *United States Pharmacopoeia Dispensing Information*; or
- the Prescription Drug Product has been recognized as safe and effective for treatment of that specific type of cancer in two articles from medical literature that have not had their recognition of the Prescription Drug Product's safety and effectiveness contraindicated by clear and convincing evidence in another article from medical literature.
- Medical literature is defined as articles from major peer reviewed medical journals specified by the *United States Department of Health and Human Services*.

[5.] Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

[6.] Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

Remove exclusion for plans that provide coverage for weight loss products.

[7.] [Any product dispensed for the purpose of appetite suppression or weight loss.]

Contraceptives are mandated in AR, except for religious group employers. [1]Remove for religious employers who choose to exclude contraceptive coverage.

[2]Include when immunizations administered in a pharmacy are covered under the Outpatient Pharmacy Rider. Select appropriate pharmacy or combination of pharmacies where coverage is provided.

.

[8.] A Pharmaceutical Product for which Benefits are provided in your *Certificate*. [[1]This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.] [[2]This exclusion does not apply to immunizations administered in a [Network] [,] [non-Network] [Network or non-Network] [or] [a Designated] Pharmacy.]

[9.] Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

[10.] General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

[11.] Unit dose packaging of Prescription Drug Products.

[12.] Medications used for cosmetic purposes.

[13.] Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.

[14.] Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

[15.] Prescription Drug Products when prescribed to treat infertility.

Contraceptives are mandated in AR, except for religious group employers. [1]Include only for religious employers who choose to exclude contraceptive coverage and make corresponding changes to Schedule of Benefits.

[[1][16.] Prescription Drug Products when prescribed to prevent conception, including, but not limited to, oral contraceptives, diaphragms, Depo Provera and other injectable drugs used for contraception.]

Include for groups that do not purchase benefits for toenail fungus treatment.

[17.] [Treatment for toenail Onychomycosis (toenail fungus).]

Include for group that do not purchase benefits for smoking cessation.

[18.] [Prescription Drug Products for smoking cessation.]

[1]Include if compounds are covered. When compound drugs are covered they are always assigned to the highest tier available under the rider. [2]Include if compounds are not covered.

[19.] [[1]Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-[2] [3] [4].)] [[2]Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.]

Remove exclusion for plans that provide coverage for OTC drugs. [1]Include if group purchases benefits for smoking cessation that include OTC drugs.

[20.] [Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.] [[1]This exclusion does not apply to over-the-counter drugs used for smoking cessation.]

Include if Benefits are not provided for New Prescription Drug Products.

[21.] [New Prescription Drug Products and/or new dosage forms until the date they are assigned to a tier by our Prescription Drug List (PDL) Management Committee.]

Always include either #1 or #2. [1]Include if growth hormone therapy is excluded for any and all conditions. [2]Include if growth hormone therapy is covered for all conditions except for children with familial short stature).

[22.] [[1]Growth hormone therapy.] [[2]Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).]

Include if Benefits are not provided on any tier.

[23.] [Any oral non-sedating antihistamine or antihistamine-decongestant combination.]

Include if Benefits are not provided on any tier.

[24.] [Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.]

[1]Include when state mandates coverage for medical foods. Adjust for any specific state required language.

[25.] Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except that Medical Foods and Low Protein Food Products are covered for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias and disorders of amino acid metabolism if the products are prescribed and administered under the direction of a Physician..

Include when the Enrolling Group requests an exclusion for one or more Therapeutic Classes.

[26.] [A particular Therapeutic Class or Therapeutic Classes. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Therapeutic Class or Therapeutic Classes are excluded.]

Include if Benefits are not provided on any tier.

[27.] [Prescription Drug Products when prescribed as sleep aids.]

Include when benefit plan design includes Therapeutic Equivalent exclusion.

[28.] [A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.]

Include when benefit plan design includes exclusion for both a modified version and Therapeutically Equivalent drug product.

[29.] [A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.]

Section 3: Defined Terms

Include if benefit design has an Annual Drug Deductible.

[**Annual Drug Deductible** - the amount you are required to pay for covered Prescription Drug Products in a year before we begin paying for Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Drug Deductible applies.]

[1]Include if either the Annual Drug Deductible or Copayment option applies.

[2]Include if Annual Drug Deductible option applies. [3]Include if the Copayment option applies.

[**Annual Out-of-Pocket Drug Maximum** - the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Out-of-Pocket Drug Maximum applies. [[1]The Annual Out-of-Pocket Drug Maximum includes the [[2]Annual Drug Deductible] [[3]Copayment].]

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Include if plan design includes designated pharmacy benefits and/or specialty prescription drug product benefits.

[1]Include for groups that purchase the specialty drug program.

[**Designated Pharmacy -** a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products[[1], including, but not limited to, Specialty Prescription Drug Products]. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.]

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Include when separate Copayment and/or Coinsurance option for preventive medications is used.

Include when drug rider is issued with a plan design that has a combined pharmacy and medical deductible, combined out of pocket or both and preventive medications are excepted from deductible or out of pocket maximum.

[1]Include when plan design includes Specialty Prescription Drug program.

[**List of Preventive Medications -** a list that identifies certain Prescription Drug Products [[1], which may include certain Specialty Prescription Drug Products,] on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may obtain the List of Preventive Medications through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

Maximum Per Drug Benefit - the maximum amount we will pay for any covered Prescription Order or Refill.

Include if Maximum Per Drug Benefit is sold.

[**Maximum Policy Drug Benefit** - the maximum amount that we will pay for Benefits for Prescription Drug Products during the entire period of time that you are enrolled under the Policy issued to the Enrolling Group.]

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our Prescription Drug List (PDL) Management Committee.
- December 31st of the following calendar year.

Include if the Per Drug Out-of-Pocket Maximum applies.

[1]Include if the Copayment option applies to this benefit plan design.

[**Per Drug Out-of-Pocket Maximum** - the maximum amount you are required to pay for a Prescription Order or Refill. [[1]The Per Drug Out-of-Pocket Maximum includes the Copayment.]]

Predominant Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. We calculate the Predominant Reimbursement Rate using our Prescription Drug Cost that applies for that particular Prescription Drug Product at most Network Pharmacies.

Prescription Drug Cost - the rate we have agreed to pay our Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.

Include when corresponding exception for immunizations administered in a pharmacy is included in exclusion #8.

- [Immunizations administered in a pharmacy.]
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;

- lancets and lancet devices; and
- glucose monitors.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Include if plan includes specialty drug program.

[1]Include when definition of List of Preventive Medications is included.

[**Specialty Prescription Drug Product -** Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. [[1]Specialty Prescription Drugs Products may include drugs on the List of Preventive Medications.] You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

Include when benefit plan design includes Copayment, Coinsurance, ancillary charges, or exclusion by Therapeutic Class.

[**Therapeutic Class -** a group or category of Prescription Drug Products with similar uses and/or actions.]

Therapeutically Equivalent - when Prescription Drug Products can be expected to produce essentially the same therapeutic outcome and toxicity.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to payment requirements as described in this *Schedule of Benefits*.

Contraceptives are mandated in AR, except for religious group employers. [1]Remove for religious employers who choose to exclude contraceptive coverage.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service[[1] or is prescribed to prevent conception].

If a Brand-name Drug Becomes Available as a Generic

[1]Include only if a tiered Copayment provision applies to this benefit design.

[2]Include only if a tiered Maximum Per Drug Benefit applies to this benefit design.

[3]Include if both a tiered Copayment provision and a tiered Maximum Per Drug Benefit apply.

[4]Include only if a tiered Specialty Drug Maximum Per Drug Benefit applies to this benefit design.

When a Prescription Drug Product becomes available as a Generic, the tier placement of the Brand-name version may change. When this occurs, [[1]your Copayment may change][[3]and] [[2]the Maximum Per Drug Benefit [([4]including the Specialty Drug Maximum Per Drug Benefit)] may change].

[1]Include only if the Copayment provision applies to this benefit design.

[2]Include only if a tiered Specialty Drug Maximum Per Drug Benefit applies to this benefit design.

[3]Include only if a Per Drug Out-of-Pocket Maximum applies to this benefit design.

If you choose to receive the Generic drug:

- [[1]You will pay the Copayment for the tier to which the Generic Prescription Drug Product is assigned.]
- You will pay the amount that exceeds the Maximum Per Drug Benefit [[2]or the Specialty Drug Maximum Per Drug Benefit] for the tier to which the Generic Prescription Drug Product is assigned.
- [[3]Your payments will be limited by the Per Drug Out-of-Pocket Maximum.]

[1]Include only if the tiered Copayment provision applies to this benefit design.

[2]Include only if a tiered Specialty Drug Maximum Per Drug Benefit applies to this benefit design.

[3]Include only if a Per Drug Out-of-Pocket Maximum applies to this benefit design.

If you choose to continue receiving the Brand-name drug or if your Physician determines that you should continue receiving the Brand-name drug:

- [[1]You will pay the Copayment for the tier to which the Brand -name Prescription Drug Product is assigned.]
- You will pay the amount that exceeds the Maximum Per Drug Benefit [[2]or the Specialty Drug Maximum Per Drug Benefit] for tier to which the Brand-name Prescription Drug Product is assigned.

- [[3]Your payments will be limited by the Per Drug Out-of-Pocket Maximum.]

The terms "generic" and "brand-name" are used in the health care industry in many different ways. To be sure that you know whether a drug is classified as Brand-name or Generic by us, please review the definitions contained in *Section 3: Defined Terms* at the end of this Rider. You should also check the current classification on the Prescription Drug List through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Supply Limits

[1]Include if the Copayment provision applies to this benefit design.

[2]Include if the Copayment provision does not apply to this benefit design.

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. [[1]For a single Copayment, you] [[2]You] may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

[1]Include when notification is required.

[2]Include when prior authorization is required.

[[1]Notification] [[2]Prior Authorization] Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to [[1]notify] [[2]obtain prior authorization from] us or our designee. The reason for [[1]notifying] [[2]obtaining prior authorization from] us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not an Experimental or Investigational or Unproven Service.

  Network Pharmacy [[1]Notification] [[2]Prior Authorization]

  When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for [[1]notifying] [[2]obtaining prior authorization from] us.

  Non-Network Pharmacy [[1]Notification] [[2]Prior Authorization]

  When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for [[1]notifying] [[2]obtaining prior authorization from] us as required.

If [[1]we are not notified] [[2]you do not obtain prior authorization from us] before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring [[1]notification] [[2]prior authorization] are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires [[1]notification] [[2]prior authorization] through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

If [[1]we are not notified] [[2]you do not obtain prior authorization from us] before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Cost) will not be available to you at a non-Network

Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

[3]Include only if either a Copayment or Annual Drug Deductible applies. Delete if there is neither a Copayment or Annual Drug Deductible requirement.

Select either [4]Copayment or [5]Annual Drug Deductible and delete the other.

[6]Include only if the Specialty Drug Maximum Per Drug Benefit applies to this benefit design.

[7]Include if the Per Drug Out-of-Pocket Maximum applies to this benefit design.

When you submit a claim on this basis, you may pay more because you did not [[1]notify] [[2]obtain prior authorization from] us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less [[3]the required [[4]Copayment] [[5]Annual Drug Deductible] and] any amount that exceeds the Maximum Per Drug Benefit [[6]or the Specialty Drug Maximum Per Drug Benefit]. The amount that you must pay is limited by [[7]the Per Drug Out-of-Pocket Maximum and] the Annual Out-of-Pocket Drug Maximum.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

Include when programs which result in enhanced Benefits are available.

[We may also require [[1]notification] [[2]prior authorization] for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable [[1]notification] [[2]prior authorization], participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

Include when step therapy requirements apply.

[Step Therapy]

[Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products for which Benefits are described in your *Certificate* are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

What You Must Pay

Include the following two paragraphs if the Copayment provision applies to this benefit design. If the Annual Drug Deductible provision applies, delete the following two paragraphs and include the Annual Drug Deductible option below.

[1]Include only if the Specialty Drug Maximum Per Drug Benefit applies.

[2]Include only if the Specialty Drug Maximum Per Drug Benefit does not apply.

[You are responsible for paying the applicable Copayment described in the *Benefit Information* table when Prescription Drug Products are obtained from a pharmacy.

After you pay the applicable Copayment, we will pay a Maximum Per Drug Benefit [[1]or a Specialty Drug Maximum Per Drug Benefit] for the Prescription Drug Product. [[2]The Maximum Per Drug Benefit is

described in the *Benefit Information* table.] [[1]The Maximum Per Drug Benefit and the Specialty Drug Maximum Per Drug Benefit are described in the *Benefit Information* table.]

Include the following two paragraphs if the Annual Drug Deductible provision applies to this benefit design. If the Copayment provision applies, delete the following two paragraphs and include the Copayment option above.

[1]Include only if the Specialty Drug Maximum Per Drug Benefit applies.

[2]Include only if the Specialty Drug Maximum Per Drug Benefit does not apply.

[You are responsible for paying the Annual Drug Deductible described in the *Payment Information* table when Prescription Drug Products are obtained from a pharmacy.

After you pay the Annual Drug Deductible, we will pay a Maximum Per Drug Benefit [[1]or a Specialty Drug Maximum Per Drug Benefit] for the Prescription Drug Product. [[2]The Maximum Per Drug Benefit is described in the *Benefit Information* table.] [[1]The Maximum Per Drug Benefit and the Specialty Drug Maximum Per Drug Benefit are described in the *Benefit Information* table.]

[1]Include when preventive medications are not subject to the Annual Drug Deductible. [2]Include when either [3]insulin or [4]diabetic supplies or [5]both are not subject to the Annual Drug Deductible.

[[1]Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.]

[[2]Benefits for [[3]insulin] [[5]or] [[4]diabetic supplies] are not subject to payment of the Annual Drug Deductible.]

Include when benefit plan has combined medical/RX deductible. When this applies, references to Annual Drug Deductible in this Rider should never be included.

[You are responsible for paying the Annual Deductible stated in the *Schedule of Benefits* which is attached to your *Certificate* before Benefits for Prescription Drug Products under this Rider are available to you.]

[1]Include when preventive medications are not subject to the Annual Deductible. [2]Include when either [3]insulin or [4]diabetic supplies or [5]both are not subject to the Annual Deductible.

[[1]Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Deductible.]

[[2]Benefits for [[3]insulin] [[5]or] [[4]diabetic supplies] are not subject to payment of the Annual Deductible.]

[1]Include only if the Specialty Drug Maximum Per Drug Benefit applies.

[2]Include if the Per Drug Out-of-Pocket Maximum applies to this benefit design.

After we pay the Maximum Per Drug Benefit [[1]or Specialty Drug Maximum Per Drug Benefit], you are responsible for paying any amount that exceeds the Maximum Per Drug Benefit [[1]or Specialty Drug Maximum Per Drug Benefit]. The amount you pay will be limited by [[2]a Per Drug Out-of-Pocket Maximum, and will be further limited by] an Annual Out-of-Pocket Drug Maximum. See the *Payment Information* table for a description of the [[2]Per Drug Out-of-Pocket Maximum and the] Annual Out-of-Pocket Drug Maximum.

Include if plan design includes a Maximum Policy Drug Benefit.

[Once you reach the Maximum Policy Drug Benefit, you no longer have Benefits for outpatient Prescription Drug Products and you are responsible for paying the full cost of any outpatient prescription medications you purchase.]

Any amount you pay for Prescription Drug Products under this Rider, including any amount you pay for a non-covered drug product, will not be included in calculating any Out-of-Pocket Maximum stated in your *Certificate.* You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Cost) will not be available to you.

Payment Information

If group purchases a plan design with an Annual Drug Deductible provision, retain the Annual Drug Deductible provision below per that plan design. The Annual Drug Deductible provision cannot apply if the Copayment provision applies.

[The Annual Drug Deductible is calculated on a [calendar] [Policy] year basis.]

The Annual Out-of-Pocket Drug Maximum is calculated on a [calendar] [Policy] year basis.

Payment Term And Description	Amounts
[Annual Drug Deductible]	
Include Annual Drug Deductible provision only if the Copayment provision does not apply. [The amount you pay for covered Prescription Drug Products in a year before we begin paying for Prescription Drug Products.] *[1]Include when preventive medications are not subject to the Annual Drug Deductible. [2]Include when either [3]insulin or [4]diabetic supplies or [5]both are not subject to the Annual Drug Deductible.* [[1]Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.][[2]Benefits for [[3]insulin] [[5]or] [[4]diabetic supplies] are not subject to payment of the Annual Drug Deductible.] *Include if the benefit plan has Annual Drug Deductible carry over provision.* *[1]Include when carry-over feature applies only to the individual portion of the Annual Drug Deductible.* [Any amount you pay that is applied to the Annual Drug Deductible in the last quarter of the previous [calendar] [Policy] year will be carried over and applied to the current Annual Drug Deductible. [[1]This carry-over feature applies only to the individual Annual Drug Deductible.]] *Include if the benefit plan has a roll over provision and applies to the group in any circumstance.* [When a Covered Person was previously covered under a group policy that was replaced by the group Policy,	*Insert deductible amounts according to benefit design chosen by group.* *Include when individual Annual Drug Deductible applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) Annual Drug Deductible applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]

Payment Term And Description	Amounts
any amount already applied to that annual drug deductible provision of the prior policy will apply to the Annual Drug Deductible provision under the Policy.] *Include if the roll-over provision applies to a group changing from a calendar year to Policy year plan. [1]Include when this applies only to the individual portion of the Annual Drug Deductible.* [When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for Prescription Drug Product expenses in the last three months of the previous calendar year that is applied to the previous Annual Drug Deductible, will be rolled over and applied to the current Policy year Annual Drug Deductible. This roll-over feature applies only to the first Policy year. [[1]This roll-over feature applies only to the individual Annual Drug Deductible.]	
Annual Out-of-Pocket Drug Maximum	
[1]Include if the Copayment option applies to this benefit design. *[2]Include only if the Specialty Drug Maximum Per Drug Benefit applies.* *[3]Include if the Annual Drug Deductible option applies.* The maximum amount you are required to pay for covered Prescription Drug Products in a year. Once you reach the Annual Out-of-Pocket Drug Maximum, you will not be required to pay [[1]Copayments or] the amount that exceeds the Maximum Per Drug Benefit [[2]or the Specialty Drug Maximum Per Drug Benefit] for covered Prescription Drug Products for the remainder of the year. [[1]The Annual Out-of-Pocket Drug Maximum includes the Copayment.] [[3]The Annual Out-of-Pocket Drug Maximum includes the Annual Drug Deductible.]	*Insert maximum amounts according to benefit design chosen by group.* *Include when individual OOPDM applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) OOPDM applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]
Include Copayment provision only if the Annual Drug Deductible provision does not apply.	

Payment Term And Description	Amounts
[Copayment]	
[The Copayment for a Prescription Drug Product at a Network or non-Network Pharmacy is a specific dollar amount. Your Copayment is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product.] *Include when programs are available for enhanced benefits.* *[1]Include when notification is required.* *[2]Include when prior authorization is required.* [Your Copayment may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable [[1]notification] [[2]prior authorization], participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] [Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment based on your actions such as adherence/compliance to medication regimens. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone	*Include Copayment provision only if the Annual Drug Deductible provision does not apply.* [For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment or • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.] *Include for groups that purchase the mail order pharmacy benefit.* [For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment or • The Prescription Drug Cost for that Prescription Drug Product.] [See the Copayments stated in the *Benefit Information* table for amounts.]

Payment Term And Description	Amounts
number on your ID card for the most up-to-date tier status.]	
Maximum Per Drug Benefit	
[1]Include when either the Copayment or the Annual Drug Deductible feature applies. [2]Include when the Annual Drug Deductible option applies. *[3]Include when the Copayment feature applies.* *[4]Include when Per Drug Out-of-Pocket Maximum applies to this benefit design.* The maximum amount we will pay [[1]after you have paid [[2]the Annual Drug Deductible] [[3]the applicable Copayment] for any covered Prescription Order or Refill before you reach the [[4]Per Drug Out-of-Pocket Maximum or the] Annual Out-of-Pocket Drug Maximum. *Include when the Maximum Per Drug Benefit is tiered.* [The Maximum per Drug Benefit is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product.] *Include when the Maximum Per Drug Benefit is tiered.* [NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call Customer Care at the telephone number on your ID card for the most up-to-date tier status.]	For Prescription Drug Products at a retail Network Pharmacy, the Maximum Per Drug Benefit is the lower of: • The applicable Maximum Per Drug Benefit, or • The Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug Product. For Prescription Drug Products at a retail non-Network Pharmacy, the Maximum Per Drug Benefit is the lower of: • The applicable Maximum Per Drug Benefit, or • The non-Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. *Include when mail order pharmacy is sold.* [For Prescription Drug Products at a mail service Network Pharmacy, the Maximum Per Drug Benefit is the lower of: • The applicable Maximum Per Drug Benefit, or • The Prescription Drug Cost for that Prescription Drug Product.] See the Maximum Per Drug Benefit stated in the *Benefit Information* table for amounts.
Include when plan includes Specialty Drug Program. **[Specialty Drug Maximum Per Drug Benefit]**	
[1]Include when either the Copayment or	[For Specialty Prescription Drug Products at a retail Network Pharmacy,

Payment Term And Description	Amounts
the Annual Drug Deductible feature applies. [2]Include when the Annual Drug Deductible option applies. *[3]Include when the Copayment feature applies.* *[4]Include when Per Drug Out-of-Pocket Maximum applies to this benefit design.* [The maximum amount we will pay [[1]after you have paid [[2]the Annual Drug Deductible] [[3]the applicable Copayment] for Prescription Order or Refill for a covered Specialty Prescription Drug Product before you reach the [[4]Per Drug Out-of-Pocket Maximum or the] Annual Out-of-Pocket Drug Maximum. *Include when the Maximum Per Drug Benefit is tiered.* [The Specialty Drug Maximum per Drug Benefit is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product.] *Include when the Maximum Per Drug Benefit is tiered.* [NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.]]	the Specialty Drug Maximum Per Drug Benefit is the lower of: • The applicable Specialty Drug Maximum Per Drug Benefit, or • The Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Specialty Prescription Drug Product. For Prescription Drug Products at a retail non-Network Pharmacy, the Specialty Drug Maximum Per Drug Benefit is the lower of: • The applicable Specialty Drug Maximum Per Drug Benefit, or • The non-Network Pharmacy's Usual and Customary Charge for the Specialty Prescription Drug Product. *Include when mail order pharmacy is sold.* [For Specialty Prescription Drug Products at a mail service Network Pharmacy, the Specialty Drug Maximum Per Drug Benefit is the lower of: • The applicable Specialty Drug Maximum Per Drug Benefit, or • The Prescription Drug Cost for that Specialty Prescription Drug Product.] See the Specialty Drug Maximum Per Drug Benefit stated in the *Benefit Information* table for amounts.]
[Include when Maximum Policy Benefit provision applies. **[Maximum Policy Drug Benefit]**	
[The maximum amount we will pay for Benefits for Prescription Drug Products during the entire period of time you are enrolled under the Policy.]	*Include when Maximum Policy Benefit provision applies.* *[1]Insert appropriate amount.* [$[[1]XXXXXX - XXXXXXX] per Covered Person.]
[Specialty Prescription Drug Product	

Payment Term And Description	Amounts
Maximum Policy Benefit]	
Include text if there is a Specialty Prescription Drug Product Maximum Policy Benefit. [The maximum amount we will pay for covered Specialty Prescription Drug Products during the entire period of time you are enrolled for coverage under the Policy.]	*Include when there is a Maximum Policy Benefit for Specialty Prescription drugs.* *Insert maximum amounts according to benefit design chosen by group.* [$[XX - XX] per Covered Person.]
[Per Drug Out-of-Pocket Maximum]	
Include only when the Per Drug Out-of-Pocket Maximum applies to this benefit design. *[1]Include only if the Specialty Drug Maximum Per Drug Benefit applies.* [The maximum amount you are required to pay for a Prescription Order or Refill. Once you reach the Per Drug Out-of-Pocket Maximum for a Prescription Order or Refill, you will not be required to pay any amount that exceeds the Maximum Per Drug Benefit [[1]or the Specialty Drug Maximum Per Drug Benefit]. The amount you are required to pay after we have paid the Maximum Per Drug Benefit [[1]or the Specialty Drug Maximum Per Drug Benefit], before you reach the Per Drug Out-of-Pocket Maximum, is based on the following: • For Prescription Drug Products from a Network Pharmacy, your payment is based on the Prescription Drug Cost. • For Prescription Drug Products from a non-Network Pharmacy, your payment is based on the Predominant Reimbursement Rate.] NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier	*Include amounts per benefit design.* *[1]Delete all text from this point through the Tier 4 description if the Per Drug OOPM is not tiered.* *[2]Include if 2-Tier.* *[3]Include if 3-Tier.* *[4]Include if 4-Tier.* *[5]Include if there is a separate Per Drug OOPM for preventive drugs.* [For up to a 31 day supply, the Per Drug Out-of-Pocket Maximum is:] [$[XX] per Prescription Order or Refill [[1]for a Tier 1 Prescription Drug Product].] [[2]$[XX] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.] [[3]$[XX] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.] [[4]$[XX] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.] [[5]$[XX] per Prescription Order or Refill for a Prescription Drug Product on the List of Preventive Medications.] *Include 62 and 90-day supply Per Drug Out-of-Pocket Maximum information if mail order is included or if benefits for maintenance medications are included. [1]Delete all text from this point through the Tier 4 description if the Per Drug OOPM is not tiered.* *[2]Include if 2-Tier.* *[3]Include if 3-Tier.* *[4]Include if 4-Tier.* *[5]Include if there is a separate Per Drug OOPM for preventive drugs.* [For a 32 day to a 62 day supply, the Per Drug Out-of-Pocket Maximum is:] [$[XX] per Prescription Order or Refill [[1]for a Tier 1 Prescription Drug Product].]

Payment Term And Description	Amounts
assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	[[2]$[XX] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.] [[3]$[XX] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.] [[4]$[XX] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.] [[5]$[XX] per Prescription Order or Refill for a Prescription Drug Product on the List of Preventive Medications.] [For a 63 day to a 90 day supply, the Per Drug Out-of-Pocket Maximum is:] [$[XX] per Prescription Order or Refill [[1]for a Tier 1 Prescription Drug Product].] [[2]$[XX] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.] [[3]$[XX] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.] [[4]$[XX] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.] [[5]$[XX] per Prescription Order or Refill for a Prescription Drug Product on the List of Preventive Medications.] *Include if the Copayment option applies.* [The Per Drug Out-of-Pocket Maximum includes the Copayment.]

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Include for groups that purchase the designated pharmacy specialty benefit. **[Specialty Prescription Drug Products]**	
[The following supply limits apply. • As written by the provider, up to a consecutive [31] [60]-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive [31]-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. *[1]Include commas and "or" as required to accommodate plan design. [2] Include when plan design includes mail order pharmacy benefits. [3]Include when plan design includes Designated Pharmacy.* Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy [[1],] [[1]or] a non-Network Pharmacy [[1],] [[1]or] [[2]a mail order Network Pharmacy] [[1]or] [[3]a Designated Pharmacy].	*Include if the Copayment option applies to this benefit design and delete Annual Drug Deductible option below.* *Benefits are provided for either a 2-Tier, 3-Tier, or 4-Tier. [1]Delete comma and include "or" when benefit design is 2 Tier. Include comma and delete "or" when benefit design is 3 Tier or more. [2] Delete comma and include "or" when benefit design is 3 Tier.[3] Include comma and delete "or" when benefit design is 4 Tier.* *[4]Always include introductory paragraph and Copayment statements when benefits are tiered.* [***For up to a [31] [60]-day supply, you must pay your Copayment:]*** [[4]Your Copayment is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3] or] [Tier-4]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] ***[Network Pharmacy]*** *Include when benefits are not tiered.* *[1]Include when there is separate Copayment for growth hormone therapy.* [100% of the Prescription Drug Cost after you pay a Copayment of $[___] per Prescription Order or Refill [[1], except that we pay 100% of the Prescription Drug Cost for a Specialty Prescription Drug Product for growth hormone therapy after you pay a Copayment of $[___]].] *Include when there is a separate Copayment statement required for drugs on the List of Preventive Medications. [1]Delete if no copayment applies to preventive drugs.* [100% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___] per Prescription Order or Refill] for a Specialty Prescription Drug Product on the List of Preventive Medications.] *Include provisions below when benefits are tiered.* *[1]Include when there is separate Copayment for growth hormone therapy.* [For a Tier-1 Specialty Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $[___] per Prescription Order or Refill [[1], except that we pay 100% of the Prescription Drug Cost for a Specialty Prescription Drug Product for growth hormone therapy after you pay a Copayment of $[___]].] *Include when there is a separate Copayment statement required for*

Description and Supply Limits	Benefit (The Amount We Pay)
	drugs on the List of Preventive Medications. [1]Delete if no copayment applies to preventive drugs.
	[For a Tier-1 Specialty Prescription Drug Product on the List of Preventive Medications: 100% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___] per Prescription Order or Refill].]
	[1]Include when there is separate Copayment for growth hormone therapy.
	[For a Tier-2 Specialty Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $[___] per Prescription Order or Refill [[1], except that we pay 100% of the Prescription Drug Cost for a Specialty Prescription Drug Product for growth hormone therapy after you pay a Copayment of $[___]].]
	Include when there is a separate Copayment statement required for drugs on the List of Preventive Medications. [1]Delete if no copayment applies to preventive drugs.
	[For a Tier-2 Specialty Prescription Drug Product on the List of Preventive Medications: 100% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___] per Prescription Order or Refill].]
	Include the paragraph below only if the benefit design is 3 Tier or more.
	[1]Include when there is separate Copayment for growth hormone therapy.
	[For a Tier-3 Specialty Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $[___] per Prescription Order or Refill [[1], except that we pay 100% of the Prescription Drug Cost for a Specialty Prescription Drug Product for growth hormone therapy after you pay a Copayment of $[___]].]
	Include when there is a separate Copayment statement required for drugs on the List of Preventive Medications. [1]Delete if no copayment applies to preventive drugs.
	[For a Tier-3 Specialty Prescription Drug Product on the List of Preventive Medications: 100% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___] per Prescription Order or Refill].]
	Include the paragraph below if the benefit design is 4 Tier.
	[1]Include when there is separate Copayment for growth hormone therapy.
	[For a Tier-4 Specialty Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $[___] per Prescription Order or Refill [[1], except that we pay 100% of the Prescription Drug Cost for a Specialty Prescription Drug Product for growth hormone therapy after you pay a Copayment of $[___]].]
	Include when there is a separate Copayment statement required for drugs on the List of Preventive Medications. [1]Delete if no copayment applies to preventive drugs.
	[For a Tier-4 Specialty Prescription Drug Product on the List of Preventive Medications: 100% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___] per Prescription Order or Refill].]
	[Non-Network Pharmacy]

Description and Supply Limits	Benefit (The Amount We Pay)
	Include when benefits are not tiered. *[1]Include when there is separate Copayment for growth hormone therapy.* [100% of the Predominant Reimbursement Rate after you pay a Copayment of $[___] per Prescription Order or Refill [[1], except that we pay 100% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy after you pay a Copayment of $[___]].] *Include when there is a separate Copayment statement required for drugs on the List of Preventive Medications. [1]Delete if no copayment applies to preventive drugs.* [100% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___] per Prescription Order or Refill] for a Specialty Prescription Drug Product on the List of Preventive Medications.] *Include provisions below when benefits are tiered.* *[1]Include when there is separate Copayment for growth hormone therapy.* [For a Tier-1 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $[___] per Prescription Order or Refill [[1], except that we pay 100% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy after you pay a Copayment of $[___]].] *Include when there is a separate Copayment statement required for drugs on the List of Preventive Medications. [1]Delete if no copayment applies to preventive drugs.* [For a Tier-1 Specialty Prescription Drug Product on the List of Preventive Medications: 100% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___] per Prescription Order or Refill].] *[1]Include when there is separate Copayment for growth hormone therapy.* [For a Tier-2 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $[___] per Prescription Order or Refill [[1], except that we pay 100% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy after you pay a Copayment of $[___]].] *Include when there is a separate Copayment statement required for drugs on the List of Preventive Medications. [1]Delete if no copayment applies to preventive drugs.* [For a Tier-2 Specialty Prescription Drug Product on the List of Preventive Medications: 100% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___] per Prescription Order or Refill].] *Include the paragraph below only if the benefit design is 3 Tier or more.* *[1]Include when there is separate Copayment for growth hormone therapy.* [For a Tier-3 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $[___] per Prescription Order or Refill [[1], except that we pay 100% of the

Description and Supply Limits	Benefit (The Amount We Pay)
	Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy after you pay a Copayment of $[___]].]
	Include when there is a separate Copayment statement required for drugs on the List of Preventive Medications. [1]Delete if no copayment applies to preventive drugs.
	[For a Tier-3 Specialty Prescription Drug Product on the List of Preventive Medications: 100% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___] per Prescription Order or Refill].]
	Include the paragraph below if the benefit design is 4 Tier.
	[1]Include when there is separate Copayment for growth hormone therapy.
	[For a Tier-4 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $[___] per Prescription Order or Refill [[1], except that we pay 100% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy after you pay a Copayment of $[___]].]
	Include when there is a separate Copayment statement required for drugs on the List of Preventive Medications. [1]Delete if no copayment applies to preventive drugs.
	[For a Tier-4 Specialty Prescription Drug Product on the List of Preventive Medications: 100% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___] per Prescription Order or Refill].]
	Include if the Annual Drug Deductible option applies to this benefit design and delete Copayment option above.
	[You must pay the Annual Drug Deductible. Once you have paid the Annual Drug Deductible, we will pay 100% of the Prescription Drug Cost until the Maximum Per Drug Benefit is reached.]
	[1]Delete if neither the Copayment option nor the Annual Drug Deductible option applies.
	[2]Delete bracketed text and all following tiering descriptions if the Maximum Per Drug Benefit is not tiered.
	[3]Include if 2-Tier.
	[4]Include if 3-Tier.
	[5]Include if 4-Tier.
	[6]Include if preventive drugs are subject to a separate maximum per drug benefit.
	[You must [[1]also] pay any amount that exceeds the Maximum Per Drug Benefit.]
	[For up to a 31 day supply, the Maximum Per Drug Benefit is:]
	[$[XX] per Prescription Order or Refill [[2]for a Tier 1 Specialty Prescription Drug Product].]
	[[6]$[XX] per Prescription Order or Refill for a [[2]Tier 1] Specialty

Description and Supply Limits	Benefit (The Amount We Pay)
	Prescription Drug Product on the List of Preventive Medications.] [[3]$[XX] per Prescription Order or Refill for a Tier 2 Specialty Prescription Drug Product.] [[6]$[XX] per Prescription Order or Refill for a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications.] [[4]$[XX] per Prescription Order or Refill for a Tier 3 Specialty Prescription Drug Product.] [[6]$[XX] per Prescription Order or Refill for a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications.] [[5]$[XX] per Prescription Order or Refill for a Tier 4 Specialty Prescription Drug Product.] [[6]$[XX] per Prescription Order or Refill for a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications.]
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. *Include for groups that purchase the mail order benefit* • [If the Network Pharmacy agrees to provide the same services or products for the same terms as the mail order Network Pharmacy, you may obtain up to a consecutive 90-day supply of a Prescription Drug Product.] *Contraceptives are mandated in AR, except for religious group employers. [1]Remove for religious employers who choose to exclude contraceptive coverage.[2]Include if the Copayment option applies to this benefit design.* • [[1]A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time [[2]if you pay a Copayment for each cycle supplied]. When you obtain up to three cycles at one time, we will pay up to three times the Maximum Per Drug Benefit.]	*Include if the Copayment option applies to this benefit design and delete Annual Drug Deductible option below.* *Always include introductory paragraph and Copayment statements when benefits are tiered. [1]Delete comma and include "or" when benefit design is 2 Tier. Include comma and delete "or" when benefit design is 3 Tier or more. [2] Delete comma and include "or" when benefit design is 3 Tier.[3] Include comma and delete "or" when benefit design is 4 Tier.* [Your Copayment is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3] or] [Tier-4]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] *[1]Delete bracketed text and all following tiering descriptions if the Copayment is not tiered.* *[2]Include if 2-Tier.* *[3]Include if 3-Tier.* *[4]Include if 4-Tier.* *[5]Include if there is a separate Copayment statement for preventive drugs.* *[6]Include if there is no copayment for preventive drugs.* ***[For up to a 31-day supply, you must pay your Copayment:]*** [100% of the Prescription Drug Cost after you pay a Copayment of $[XX] per Prescription Order or Refill [[1]for a Tier 1 Prescription Drug Product]. [[5]100% of the Prescription Drug Cost [[6]after you pay a Copayment of $[XX]] per Prescription Order or Refill for a [[1]Tier 1] Prescription Drug Product on the List of Preventive Medications.] [[2]100% of the Prescription Drug Cost after you pay a Copayment of

Description and Supply Limits	Benefit (The Amount We Pay)
	$[XX] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.] [[5]100% of the Prescription Drug Cost [[6]after you pay a Copayment of $[XX]] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.] [[3]100% of the Prescription Drug Cost after you pay a Copayment of $[XX] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.] [[5]100% of the Prescription Drug Cost [[6]after you pay a Copayment of $[XX]] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.] [[4]100% of the Prescription Drug Cost after you pay a Copayment of $[XX] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.] [[5]100% of the Prescription Drug Cost [[6]after you pay a Copayment of $[XX]] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.] *Include if the Annual Drug Deductible option applies to this benefit design and delete Copayment option above.* ***[You must pay the Annual Drug Deductible. Once you have paid the Annual Drug Deductible, we will pay 100% of the Prescription Drug Cost until the Maximum Per Drug Benefit is reached.]*** *[1]Delete if neither the Copayment option nor the Annual Drug Deductible option applies.* *[2]Delete bracketed text and all following tiering descriptions if the Maximum Per Drug Benefit is not tiered.* *[3]Include if 2-Tier.* *[4]Include if 3-Tier.* *[5]Include if 4-Tier.* *[6]Include if preventive drugs are subject to a separate maximum per drug benefit.* ***[You must [[1]also] pay any amount that exceeds the Maximum Per Drug Benefit.]*** **[For up to a 31 day supply, the Maximum Per Drug Benefit is:]** $[XX] per Prescription Order or Refill [[2]for a Tier 1 Prescription Drug Product]. [[6]$[XX] per Prescription Order or Refill for a [[2]Tier 1] Prescription Drug Product on the List of Preventive Medications.] [[3]$[XX] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.] [[6]$[XX] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.] [[4]$[XX] per Prescription Order or Refill for a Tier 3 Prescription Drug

Description and Supply Limits	Benefit (The Amount We Pay)
	Product.] [[6]$[XX] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.] [[5]$[XX] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.] [[6]$[XX] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.]
Prescription Drugs from a Retail Non-Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. *Contraceptives are mandated in AR, except for religious group employers. [1]Remove for religious employers who choose to exclude contraceptive coverage.[2]Include if the Copayment option applies to this benefit design.* • [[1]A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time [[2]if you pay a Copayment for each cycle supplied]. When you obtain up to three cycles at one time, we will pay up to three times the Maximum Per Drug Benefit.] [[1]When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment that applies will reflect the number of days dispensed.]	*Include if the Copayment option applies to this benefit design and delete Annual Drug Deductible option below.* *Always include introductory paragraph and Copayment statements when benefits are tiered. [1]Delete comma and include "or" when benefit design is 2 Tier. Include comma and delete "or" when benefit design is 3 Tier or more. [2] Delete comma and include "or" when benefit design is 3 Tier.[3] Include comma and delete "or" when benefit design is 4 Tier.* [Your Copayment is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3] or] [Tier-4]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] *[1]Delete bracketed text and all following tiering descriptions if the Copayment is not tiered.* *[2]Include if 2-Tier.* *[3]Include if 3-Tier.* *[4]Include if 4-Tier.* *[5]Include if there is a separate Copayment statement for preventive drugs.* *[6]Include if there is no copayment for preventive drugs.* ***[For up to a 31-day supply, you must pay your Copayment:]*** [100% of the Predominant Reimbursement Rate after you pay a Copayment of $[XX] per Prescription Order or Refill [[1]for a Tier 1 Prescription Drug Product].] [[5]100% of the Predominant Reimbursement Rate [[6]after you pay a Copayment of $[XX]] per Prescription Order or Refill for a [[1]Tier 1] Prescription Drug Product on the List of Preventive Medications.] [[2]100% of the Predominant Reimbursement Rate after you pay a Copayment of $[XX] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.] [[5]100% of the Predominant Reimbursement Rate [[6]after you pay a Copayment of $[XX]] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.] [[3]100% of the Predominant Reimbursement Rate after you pay a

Description and Supply Limits	Benefit (The Amount We Pay)
	Copayment of $[XX] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.] [[5]100% of the Predominant Reimbursement Rate [[6]after you pay a Copayment of $[XX]] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.] [[4]100% of the Predominant Reimbursement Rate after you pay a Copayment of $[XX] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.] [[5]100% of the Predominant Reimbursement Rate [[6]after you pay a Copayment of $[XX]] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.] *Include if the Annual Drug Deductible option applies to this benefit design and delete Copayment option above.* ***[You must pay the Annual Drug Deductible. Once you have paid the Annual Drug Deductible, we will pay 100% of the Prescription Drug Cost until the Maximum Per Drug Benefit is reached.]*** *[1]Delete if neither the Copayment option nor the Annual Drug Deductible option applies.* *[2]Delete bracketed text and all following tiering descriptions if the Maximum Per Drug Benefit is not tiered.* *[3]Include if 2-Tier.* *[4]Include if 3-Tier.* *[5]Include if 4-Tier.* *[6]Include if preventive drugs are subject to a separate maximum per drug benefit.* ***[You must [[1]also] pay any amount that exceeds the Maximum Per Drug Benefit.]*** **[For up to a 31 day supply, the Maximum Per Drug Benefit is:]** [$[XX] per Prescription Order or Refill [[2]for a Tier 1 Prescription Drug Product].] [[6]$[XX] per Prescription Order or Refill for a [[2]Tier 1] Prescription Drug Product on the List of Preventive Medications.] [[3]$[XX] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.] [[6]$[XX] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.] [[4]$[XX] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.] [[6]$[XX] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.] [[5]$[XX] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.]

Description and Supply Limits	Benefit (The Amount We Pay)
	[[6]$[XX] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.]
Include for groups that purchase the mail order benefit. **[Prescription Drug Products from a Mail Order Network Pharmacy]**	
[The following supply limits apply: *[1]Include if benefit plan design includes specialty drug program.* *[2]Include if benefit plan design includes the List of Preventive Medications.* • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. [[1]These supply limits do not apply to Specialty Prescription Drug Products[[2], including Specialty Prescription Drug Products on the List of Preventive Medications]. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products*.] *Include if coverage is initially required at a retail pharmacy prior to using mail order.* [You may be required to fill an initial Prescription Drug Product order and obtain [1 - 3] refill[s] through a retail pharmacy prior to using a mail order Network Pharmacy.] *Include the following paragraph only when mail order Copayments in the right hand column are charged for the full 90 day supply. Delete if Copayments are tied to the 31, 60 and 90 day supply.* [To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment for any Prescription Orders or Refills sent to the	*Include if the Copayment option applies to this benefit design and delete Annual Drug Deductible option below.* *Always include introductory paragraph and Copayment statements when benefits are tiered. [1]Delete comma and include "or" when benefit design is 2 Tier. Include comma and delete "or" when benefit design is 3 Tier or more. [2] Delete comma and include "or" when benefit design is 3 Tier.[3] Include comma and delete "or" when benefit design is 4 Tier.* [Your Copayment is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3] or] [Tier-4]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] *[1]Delete bracketed text and all following tiering descriptions if the Copayment is not tiered.* *[2]Include if 2-Tier.* *[3]Include if 3-Tier.* *[4]Include if 4-Tier.* *[5]Include if there is a separate Copayment statement for preventive drugs.* *[6] Delete if there is no copayment required for preventive drugs.* ***[[1]You must pay your Copayment:*** **[For up to a 31 day supply, your Copayment is:]** [100% of the Prescription Drug Cost after you pay a Copayment of $[XX] per Prescription Order or Refill [[1]for a Tier 1 Prescription Drug Product].] [[5]100% of the Prescription Drug Cost [[6]after you pay a Copayment of $[XX]] per Prescription Order or Refill for a [[1]Tier 1] Prescription Drug Product on the List of Preventive Medications.] [[2]100% of the Prescription Drug Cost after you pay a Copayment of $[XX] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.] [[5]100% of the Prescription Drug Cost [[6]after you pay a Copayment of $[XX]] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.] [[3]100% of the Prescription Drug Cost after you pay a Copayment of $[XX] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.] [[5]100% of the Prescription Drug Cost [[6]after you pay a Copayment of

Description and Supply Limits	Benefit (The Amount We Pay)
mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.]	$[XX]] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.] [[4]100% of the Prescription Drug Cost after you pay a Copayment of $[XX] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.] [[5]100% of the Prescription Drug Cost [[6]after you pay a Copayment of $[XX]] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.] **[For a 32 day to a 62 day supply, your Copayment is:]** [100% of the Prescription Drug Cost after you pay a Copayment of $[XX] per Prescription Order or Refill [[1]for a Tier 1 Prescription Drug Product].] [[5]100% of the Prescription Drug Cost [[6]after you pay a Copayment of $[XX]] per Prescription Order or Refill for a [[1]Tier 1] Prescription Drug Product on the List of Preventive Medications.] [[2]100% of the Prescription Drug Cost after you pay a Copayment of $[XX] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.] [[5]100% of the Prescription Drug Cost [[6]after you pay a Copayment of $[XX]] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.] [[3]100% of the Prescription Drug Cost after you pay a Copayment of $[XX] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.] [[5]100% of the Prescription Drug Cost [[6]after you pay a Copayment of $[XX]] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.] [[4]100% of the Prescription Drug Cost after you pay a Copayment of $[XX] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.] [[5]100% of the Prescription Drug Cost [[6]after you pay a Copayment of $[XX]] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.] **[For a 63 day to a 90 day supply, your Copayment is:]** [100% of the Prescription Drug Cost after you pay a Copayment of $[XX] per Prescription Order or Refill [[1]for a Tier 1 Prescription Drug Product].] [[5]100% of the Prescription Drug Cost [[6]after you pay a Copayment of $[XX]] per Prescription Order or Refill for a [[1]Tier 1] Prescription Drug Product on the List of Preventive Medications.] [[2]100% of the Prescription Drug Cost after you pay a Copayment of $[XX] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.] [[5]100% of the Prescription Drug Cost [[6]after you pay a Copayment of $[XX]] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.]

Description and Supply Limits	Benefit (The Amount We Pay)
	[[3]100% of the Prescription Drug Cost after you pay a Copayment of $[XX] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.] [[5]100% of the Prescription Drug Cost [[6]after you pay a Copayment of $[XX]] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.] [[4]100% of the Prescription Drug Cost after you pay a Copayment of $[XX] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.] [[5]100% of the Prescription Drug Cost [[6]after you pay a Copayment of $[XX]] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.] *Include if the Annual Drug Deductible option applies to this benefit design and delete Copayment option above.* ***[You must pay the Annual Drug Deductible. Once you have paid the Annual Drug Deductible, we will pay 100% of the Prescription Drug Cost until the Maximum Per Drug Benefit is reached.]*** *[1]Delete if neither the Copayment option nor the Annual Drug Deductible option applies.* *[2]Delete bracketed text and all following tiering descriptions if the Maximum Per Drug Benefit is not tiered.* *[3]Include if 2-Tier.* *[4]Include if 3-Tier.* *[5]Include if 4-Tier.* *[6]Include if preventive drugs are subject to a separate maximum per drug benefit.* ***[You must [[1]also] pay any amount that exceeds the Maximum Per Drug Benefit.]*** **[For up to a 31 day supply, the Maximum Per Drug Benefit is:]** [$[XX] per Prescription Order or Refill [[2]for a Tier 1 Prescription Drug Product].] [[6]$[XX] per Prescription Order or Refill for a [[2]Tier 1] Prescription Drug Product on the List of Preventive Medications.] [[3]$[XX] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.] [[6]$[XX] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.] [[4]$[XX] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.] [[6]$[XX] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.] [[5]$[XX] per Prescription Order or Refill for a Tier 4 Prescription Drug

Description and Supply Limits	Benefit (The Amount We Pay)
	Product.] [[6]$[XX] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.] **[For a 32 day to a 62 day supply, the Maximum Per Drug Benefit is:]** [$[XX] per Prescription Order or Refill [[2]for a Tier 1 Prescription Drug Product].] [[6]$[XX] per Prescription Order or Refill for a [[2]Tier 1] Prescription Drug Product on the List of Preventive Medications.] [[3]$[XX] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.] [[6]$[XX] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.] [[4]$[XX] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.] [[6]$[XX] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.] [[5]$[XX] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.] [[6]$[XX] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.] **[For a 63 day to a 90 day supply, the Maximum Per Drug Benefit is:]** [$[XX] per Prescription Order or Refill [[2]for a Tier 1 Prescription Drug Product].] [[6]$[XX] per Prescription Order or Refill for a [[2]Tier 1] Prescription Drug Product on the List of Preventive Medications.] [[3]$[XX] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.] [[6]$[XX] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.] [[4]$[XX] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.] [[6]$[XX] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.] [[5]$[XX] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.] [[6]$[XX] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.]

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

[1]Include when the only Brand-name coverage is for diabetic supplies and insulin.

[2]Include when Brand-name coverage is available for diabetic supplies and insulin, as well as for at least one other state mandated drug.

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for outpatient Generic Prescription Drug Products. All references to Benefits for Prescription Drug Products in this Rider and the attached *Schedule of Benefits* refer to Benefits only for Generic Prescription Drug Products unless otherwise explicitly noted. This Rider does not provide Benefits for Brand-name Prescription Drug Products[[1], except for Brand-name diabetic supplies and insulin.] [[2]except for the following as required by state law:]

[1]Remove for religious employers who choose to exclude contraceptive coverage.

- Brand-name diabetic supplies and insulin.
- [[1]Brand-name contraceptives.]

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and in this Rider in *Section 3: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

Include only one of the three COB options listed below.

Include if COB does not apply to RX benefits.

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.]

Include if COB applies to RX benefits.

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the *Certificate*.]

Include if COB applies only to Medicare Part B and/or D. Include Part B, D or both option when applicable.

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider, except that Benefits for Prescription Drug Products will be coordinated with prescription drug benefits provided under Medicare [Part B] [Part D] [Parts B and D].]

_____

(Name and Title)

Introduction

Coverage Policies and Guidelines

[1]Include when notification is required.

[2]Include when prior authorization is required.

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or [[1]notification] [[2]prior authorization] requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others, therefore a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

[1]Include when the benefit plan design includes Therapeutic Class Charge.

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment and/or Coinsurance[[1],Therapeutic Class Charge,] and any deductible that applies.

Include the name and address of the appropriate Pharmacy Benefit Manager.

Submit your claim to:

[Name of Pharmacy Benefit Manager]

[Address of Pharmacy Benefit Manager]

[City, State and Zip Code]

Include for groups that purchase the designated pharmacy benefit. Designated pharmacy can be utilized for more than the specialty drug program. It applies to specialty when #1 below is included.

[1]Include when benefit plan design includes specialty drug program.

[Designated Pharmacies]

[If you require certain Prescription Drug Products [[1], including, but not limited to, Specialty Prescription Drug Products,] we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Prescription Drug Product.]

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

[1]Include if the Annual Drug Deductible applies. [2]Include only when plans pass rebates on to customers. [3]Include for all other plans.

We may receive rebates for certain drugs included on the Prescription Drug List [[1], including those drugs that you purchase prior to meeting your Annual Drug Deductible]. We [[2]do] [[3]do not] pass these rebates on to you, [[2]and they are] [[3]nor are they] [[1]applied to your Annual Drug Deductible or] taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Prescription Drug Rider. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug Rider. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication regimens. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Outpatient Prescription Drug Rider Table of Contents

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Section 1: Benefits for Prescription Drug Products

Benefits are available for Generic Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

[1]Remove for religious employers who choose to exclude contraceptive coverage.

[2]Include for group that purchase closed-panel benefits and the corresponding exclusion is included in Section 2. (Closed panel means that we pay only for drugs that are prescribed by a Network provider.)

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service [[1]or is prescribed to prevent conception]. [[2]Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

Include when plan includes Specialty Drug Program.

[Specialty Prescription Drug Products]

[Benefits are provided for Specialty Prescription Drug Products.

[1]Include for groups that purchase Designated Pharmacy benefit.

[[1]If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Specialty Prescription Drug Product.]

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product [[1]and Designated Pharmacy].

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.]

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Prescription Drugs from a Retail Non-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail non-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with us, as described in *Section 5* of your *Certificate*. We will not reimburse you for the difference between the Predominant Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail non-Network Pharmacy supply limits.

Include for groups that purchase the mail order benefit option.

[Prescription Drug Products from a Mail Order Network Pharmacy]

[Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on mail order Network Pharmacy supply limits.

Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.]

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* apply also to this Rider, except that any preexisting condition exclusion in the *Certificate* is not applicable to this Rider. In addition, the exclusions listed below apply.

1. Brand-name Prescription Drug Products which are not otherwise specifically stated in this Rider as covered.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

[1]Remove only when Enrolling Group requests coverage for non-Emergency drugs dispensed outside the U.S.

[3.] [[1]Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.]

[4.] Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.

[5.] Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion will not apply to Prescription Drug Products approved by the *United States Food and Drug Administration (USFDA)* for use in the treatment of cancer on the basis that the Prescription Drug Product has not been approved by the *USFDA* for the treatment of the specific type of cancer for which the Prescription Drug Product has been prescribed, provided:

- the Prescription Drug Product has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one or more compendia:
  - the *American Hospital Formulary Service Drug Information*;
  - the *United States Pharmacopoeia Dispensing Information*; or
- the Prescription Drug Product has been recognized as safe and effective for treatment of that specific type of cancer in two articles from medical literature that have not had their recognition of the Prescription Drug Product's safety and effectiveness contraindicated by clear and convincing evidence in another article from medical literature.

  Medical literature is defined as articles from major peer reviewed medical journals specified by the *United States Department of Health and Human Services*.

[6.] Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

[7.] Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

Remove exclusion for plans that provide coverage for weight loss products.

[8.] [Any product dispensed for the purpose of appetite suppression or weight loss.]

[1]Remove for religious employers who choose to exclude contraceptive coverage. [2]Include when immunizations administered in a pharmacy are covered under the Outpatient Pharmacy Rider. Select appropriate pharmacy or combination of pharmacies where coverage is provided.

[9.] A Pharmaceutical Product for which Benefits are provided in your *Certificate of Coverage*. [[1]This exclusion does not apply to covered injectable drugs used for contraception.] [[2]This exclusion does not apply to immunizations administered in a [Network] [,] [non-Network] [Network or non-Network] [or] [a Designated] Pharmacy.]

[10.] Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

[11.] General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

[12.] Unit dose packaging of Prescription Drug Products.

[13.] Medications used for cosmetic purposes.

[14.] Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.

[15.] Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

[16.] Prescription Drug Products when prescribed to treat infertility.

[1]Include for religious employers who choose to exclude contraceptive coverage.

[[1][17.] Prescription Drug Products when prescribed to prevent conception, including, but not limited to, oral contraceptives, diaphragms, and injectable drugs used for contraception.]

Include for groups that do not purchase benefits for toenail fungus treatment.

[18.] [Treatment for toenail Onychomycosis (toenail fungus).]

Include for group that do not purchase benefits for smoking cessation.

[19.] [Prescription Drug Products for smoking cessation.]

Include for groups that purchase a closed benefit plan design. Delete for groups that purchase an open benefit plan design (open benefit plan provides coverage at all tier levels). Include commas and "or" as applicable to the level of Closed Benefit Plan.

[20.] [Prescription Drug Products not included on Tier-1 [,] [or] [Tier-2] [,] [or] [Tier-3] [,] [or] [Tier-4] of the Prescription Drug List at the time the Prescription Order or Refill is dispensed.]

Include for groups that purchased closed-panel benefits. (Closed panel means that we pay only for drugs that are prescribed by a Network provider.)

[21]. [A Prescription Drug Product prescribed by a non-Network Physician or other non-Network provider.]

[22.] Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.

Remove exclusion for plans that provide coverage for OTC drugs. [1]Include if group purchases benefits for smoking cessation that include OTC drugs.

[23.] [Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.] [[1]This exclusion does not apply to over-the-counter drugs used for smoking cessation.]

Include if Benefits are not provided for New Prescription Drug Products.

[24.] [New Prescription Drug Products and/or new dosage forms until the date they are assigned to a tier by our Prescription Drug List (PDL) Management Committee.]

[25.] Growth hormone therapy.

Include if Benefits are not provided on any tier.

[26.] [Any oral non-sedating antihistamine or antihistamine-decongestant combination.]

Include if Benefits are not provided on any tier.

[27.] [Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.]

[1]*Include when state mandates coverage for medical foods. Adjust for any specific state required language.*

[28.] Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury,except that Medical Foods and Low Protein Modified Food Products are covered, as described in Section 1: Covered Health Services of the Certificate, for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias and disorders of amino acid metabolism if the products are prescribed and administered under the direction of a Physician.

Include when the Enrolling Group requests an exclusion for one or more Therapeutic Classes.

[29.] [A particular Therapeutic Class or Therapeutic Classes. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Therapeutic Class or Therapeutic Classes are excluded.]

Include if Benefits are not provided on any tier.

[30.] [Prescription Drug Products when prescribed as sleep aids.]

Include when benefit plan design includes Therapeutic Equivalent exclusion.

[31.] [A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.]

Include when benefit plan design includes exclusion for both a modified version and Therapeutically Equivalent drug product.

[32.] [A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.]

Section 3: Defined Terms

Include if benefit design has an Annual Drug Deductible.

[1]Include if the Annual Drug Deductible provision applies only to Tier-2, Tier-3 and Tier-4 Prescription Drug Products. (Include commas and "ands" as applicable to the number of tiers covered under this Rider.)

[**Annual Drug Deductible** - the amount you are required to pay for covered [[1][Tier-2] [,] [and] [Tier-3] [,] [and] [Tier-4]] Prescription Drug Products in a year before we begin paying for Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Drug Deductible applies.]

Include if benefit design has an Annual Maximum Drug Benefit.

[**Annual Maximum Drug Benefit -** the maximum amount we will pay for Prescription Drug Products during a year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Maximum Drug Benefit applies.]

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Include if plan design includes designated pharmacy benefits and/or specialty prescription drug product benefits.

[1]Include for groups that purchase the specialty drug program.

[**Designated Pharmacy -** a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products[[1], including, but not limited to, Specialty Prescription Drug Products]. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.]

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Contract Specialist. Only include when the treatment of Infertility is a state mandated benefit. Remove brackets for filing.

[Infertility - failure to achieve a Pregnancy after a year of regular unprotected intercourse if the woman is under age 35, or after six months if the woman is over age 35. In addition, in order to be eligible for Benefits, the Covered Person must also:

- Be under age 44, if female.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.]

Contract Specialists. Only include this option if Infertility is a state mandated benefit and an annual maximum is allowed. Retain brackets for filing.

Include if benefit design has an Infertility Annual Maximum Benefit.

[**Infertility Annual Maximum Benefit** - the maximum amount we will pay for covered Prescription Drug Products for Infertility during a year. Refer to the Outpatient Prescription Drug Schedule of Benefits for details about how the Infertility Annual Maximum Benefit applies.]

Contract Specialists. Only include this option if Infertility is a state mandated benefit and a separate infertility Maximum Policy Benefit is allowed. Retain brackets for filing.

Include if benefit design has an Infertility Maximum Policy Benefit.

[**Infertility Maximum Policy Benefit** - the maximum amount we will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Policy. Refer to the Outpatient Prescription Drug Schedule of Benefits for details about how the Infertility Maximum Policy Benefit applies.]

Include when separate Copayment and/or Coinsurance option for preventive medications is used.

Include when drug rider is issued with a plan design that has a combined pharmacy and medical deductible, combined out of pocket or both and preventive medications are excepted from deductible or out of pocket maximum.

[1]*Include when plan design includes Specialty Prescription Drug program.*

[**List of Preventive Medications -** a list that identifies certain Prescription Drug Products [[1], which may include certain Specialty Prescription Drug Products,] on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may obtain the List of Preventive Medications through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our Prescription Drug List (PDL) Management Committee.
- December 31st of the following calendar year.

Include when plan design includes increased Copayments or Coinsurance when a Non-Preferred Retail Network Pharmacy is utilized.

[**Non-Preferred Retail Network Pharmacy** - a pharmacy that we identify as a non-preferred pharmacy within the Network.]

Include if Copayments and/or Coinsurance are limited by an Out-of-Pocket Drug Maximum.

[**Out-of-Pocket Drug Maximum -** the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Out-of-Pocket Drug Maximum applies.]

Predominant Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. We calculate the Predominant Reimbursement Rate using our Prescription Drug Cost that applies for that particular Prescription Drug Product at most Network Pharmacies.

Include when plan design includes reduced Copayments or Coinsurance when a Preferred Retail Network Pharmacy is utilized.

[**Preferred Retail Network Pharmacy** - a pharmacy that we identify as a preferred pharmacy within the Network.]

Prescription Drug Cost - the rate we have agreed to pay our Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- [Inhalers (with spacers).]
- Oral diabetic agents.
- Insulin.

[1]Include when corresponding exception for immunizations administered in a pharmacy is included in exclusion #8

- [[1]Immunizations administered in a pharmacy.]
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Include if plan includes specialty drug program.

[2]Include when definition of List of Preventive Medications is included.

[**Specialty Prescription Drug Product -** Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. [[[2]Specialty Prescription Drug Products may include drugs on the List of Preventive Medications.] You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

Include if Copayments and/or Coinsurance are limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.

[**Specialty Prescription Drug Product Out-of-Pocket Maximum -** the maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Specialty Prescription Drug Product Out-of-Pocket Maximum applies.]

Include when benefit plan design includes Copayment, Coinsurance, ancillary charges, or exclusion by Therapeutic Class.

[**Therapeutic Class -** a group or category of Prescription Drug Products with similar uses and/or actions.]

Include when benefit plan design includes Therapeutic Class Charge.

[**Therapeutic Class Charge -** a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product that is dispensed at your or your provider's request is in a Therapeutic Class where we have determined a maximum allowable cost. For Prescription Drug Products from Network Pharmacies, the Therapeutic Class Charge is calculated as the difference between the Prescription Drug Cost for Network Pharmacies for the Prescription Drug Product dispensed and the maximum allowable cost for the Therapeutic Class. For Prescription Drug Products from non-Network Pharmacies, the Therapeutic Class Charge is calculated as the difference between the Predominant Reimbursement Rate for the Prescription Drug Product dispensed and the maximum allowable cost for the Therapeutic Class.]

Therapeutically Equivalent - when Prescription Drug Products can be expected to produce essentially the same therapeutic outcome and toxicity.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

Benefits for Prescription Drug Products

[1]Include when the only Brand-name coverage is for diabetic supplies and insulin.

[2]Include when Brand-name coverage is available for diabetic supplies and insulin, as well as for at least one other state mandated drug.

Benefits are available for Generic Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Generic Prescription Drug Product is listed. Benefits are also available for [[1]Brand-name diabetic supplies and insulin.] [[2]the following:]

[1]Remove for religious employers who choose to exclude contraceptive coverage.

- Brand-name diabetic supplies and insulin.
- [[1]Brand-name contraceptives.]

Include for groups that purchase closed-panel benefits and the corresponding exclusion is included in Section 2. (Closed panel means that we pay only for drugs that are prescribed by a Network provider.)

[Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

[1]Remove for religious employers who choose to exclude contraceptive coverage.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service [[1]or is prescribed to prevent conception].

If a Brand-name Drug Becomes Available as a Generic

If a Prescription Drug Product becomes available as a Generic, Benefits for that Prescription Drug Product may become available to you under this Rider. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

The terms "generic" and "brand-name" are used in the health care industry in many different ways. To be sure that you know whether a drug is classified as Brand-name or Generic by us, please review the definitions contained in *Section 3: Defined Terms*. You should also check the current classification on the Prescription Drug List through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

[1]Include when notification is required.

[2]Include when prior authorization is required.

[[1]Notification] [[2]Prior Authorization] Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to [[1]notify] [[2]obtain prior authorization from] us or our designee. The reason for [[1]notifying] [[2]obtaining prior authorization from] us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not an Experimental or Investigational or Unproven Service.

Network Pharmacy [[1]Notification] [[2]Prior Authorization]

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for [[1]notifying] [[2]obtaining prior authorization from] us.

Non-Network Pharmacy [[1]Notification] [[2]Prior Authorization]

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for [[1]notifying] [[2]obtaining prior authorization from] us as required.

If [[1]we are not notified] [[2]you do not obtain prior authorization from us] before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring [[1]notification] [[2]prior authorization] are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires [[1]notification] [[2]prior authorization] through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

If [[1]we are not notified] [[2]you do not obtain prior authorization from us] before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Cost) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

[1]Include when benefit plan design includes Therapeutic Class Charge.

When you submit a claim on this basis, you may pay more because you did not [[1]notify] [[2]obtain prior authorization from] us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance [[1], Therapeutic Class Charge] and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

Include when programs which result in enhanced Benefits are available.

[We may also require [[1]notification] [[2]prior authorization] for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such

programs. You may access information on available programs and any applicable [[1]notification] [[2]prior authorization], participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

Include when step therapy requirements apply.

[Step Therapy]

[Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products for which Benefits are described in your *Certificate* are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

What You Must Pay

[1]Include if the benefit plan design has an Annual Drug Deductible.

[[1]You are responsible for paying the Annual Drug Deductible.]

[1]Include when preventive medications are not subject to the Annual Drug Deductible. [2]Include when either [3]insulin or [4]diabetic supplies or [5]both are not subject to the Annual Drug Deductible.

[[1]Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.]

[[2]Benefits for [[3]insulin] [[5]or] [[4]diabetic supplies] are not subject to payment of the Annual Drug Deductible.]

Include when benefit plan has combined medical/RX deductible. When this applies, references to Annual Drug Deductible in this Rider should never be included.

[You are responsible for paying the Annual Deductible stated in the *Schedule of Benefits* which is attached to your *Certificate* before Benefits for Prescription Drug Products under this Rider are available to you.]

[1]Include when preventive medications are not subject to the Annual Deductible. [2]Include when either [3]insulin or [4]diabetic supplies or [5]both are not subject to the Annual Deductible.

[[1]Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Deductible.]

[[2]Benefits for [[3]insulin] [[5]or] [[4]diabetic supplies] are not subject to payment of the Annual Deductible.]

[1]Include when the benefit plan design includes Therapeutic Class Charge.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table [[1], in addition to any Therapeutic Class Charge].

Include when benefit plan design includes Therapeutic Class Charge.

[A Therapeutic Class Charge may apply when the Prescription Drug Cost or the Predominant Reimbursement Rate of the Prescription Drug Product exceeds the maximum amount we allow for a drug in the Prescription Drug Product's Therapeutic Class. You are responsible for the Therapeutic Class Charge and any applicable Copayment and/or Coinsurance.]

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in your *Certificate*:

Include when Copayments are NOT applied to the overall OOPM in the COC. [1]Include when benefit plan design includes Specialty Drug Copayments.

- [Copayments for Prescription Drug Products [[1], including Specialty Prescription Drug Products].]

Include when Coinsurance is NOT applied to the overall OOPM in the COC. [1]Include when benefit plan design includes Specialty Drug Coinsurance.

- [Coinsurance for Prescription Drug Products [[1], including Specialty Prescription Drug Products].]

Include when benefit plan design includes Therapeutic Class Charge.

- [Therapeutic Class Charges.]

Include if the Annual Drug Deductible provision applies, however delete if the Annual Drug Deductible is included in the Annual Deductible in the Medical COC and the OOPM in the COC includes the Annual Deductible.

- [The Annual Drug Deductible.]

Include if the Annual Maximum Drug Benefit applies.

- [Any amount you pay for Prescription Drug Products that exceeds the Annual Maximum Drug Benefit.]

Include if the Infertility Annual Maximum Benefit applies.

- [Any amount you pay for Prescription Drug Products for Infertility that exceeds the Infertility Annual Maximum Benefit.]

Include if Infertility Maximum Policy Benefit applies.

- [Any amount you pay for Prescription Drug Products for Infertility that exceeds the Infertility Maximum Policy Benefit.]
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Cost) will not be available to you.

Payment Information

If group purchases a plan design with an Annual Drug Deductible provision, retain the Annual Drug Deductible provision below per that plan design.

If group purchases a plan design with an Out-of-Pocket Drug Maximum, include Out-of-Pocket Drug Maximum.

If group purchases a plan design with a Specialty Prescription Drug Product Out-of-Pocket Maximum, include the Specialty Prescription Drug Product Out-of-Pocket Maximum.

If group purchases a plan design with an Annual Maximum Drug Benefit, include Annual Maximum Drug Benefit.

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

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

[The Specialty Prescription Drug Product Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.]

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

Contract Specialist - Only include this option if your state mandates coverage for Infertility and allows an Infertility Annual Maximum Benefit.

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

Payment Term And Description	Amounts
[Annual Drug Deductible]	
Select either Option 1 or Option 2, if there is an Annual Drug Deductible. *Option 1: Include the following paragraph and corresponding deductible language if application of the Annual Drug Deductible is determined based on Network or Non-Network status.* *[1]Include if the Annual Drug Deductible provision applies only to Tier-2, Tier-3, and/or Tier 4 Prescription Drug Products. (Include commas and "ands" as applicable to the number of tiers covered under this rider.) [2]Include if the Annual Drug Deductible applies only to Network Benefits. [3]Include if the Annual Drug Deductible applies only to Non-Network Benefits. [4] Include if the Annual Drug Deductible applies to both Network and Non-Network Benefits. Select options in table accordingly.* [The amount you pay for covered [[1][Tier-2] [,] [and] [Tier-3] [,] [and] [Tier-4]] Prescription Drug Products [[2]at a Network Pharmacy] [[3]at a non-Network Pharmacy] [[4]at a Network or non-Network Pharmacy] in a year before we	*The option below corresponds with Option 1.* *Insert deductible amounts according to benefit design chosen by group.* ***[[2]Network]*** [No Annual Drug Deductible.] *Include when individual Annual Drug Deductible applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) Annual Drug Deductible applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] **[[3]*Non-Network]*** [No Annual Drug Deductible.] *Include when individual Annual Drug Deductible applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) Annual Drug Deductible applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] ***[[4]Network and Non-Network]***

Payment Term And Description	Amounts
begin paying for Prescription Drug Products.]	*Include when individual Annual Drug Deductible applies.*
Option 2: Include the following paragraph and corresponding deductible language when the application of the Annual Drug Deductible is determined based on tier status.	[$[XX – XX] per Covered Person.]
[1]Include the tiers that the Annual Drug Deductible provision applies to: Tier-1, Tier-2, Tier-3 and/or Tier 4 Prescription Drug Products. (Include commas and "ands" as applicable to the number of tiers covered under this Rider.) [2]Include if the Annual Drug Deductible applies only to Network Benefits. [3]Include if the Annual Drug Deductible applies only to Non-Network Benefits. [4] Include if the Annual Drug Deductible applies to both Network and Non-Network Benefits.	*Include when individual (with family maximum) Annual Drug Deductible applies.*
[The amount you pay for covered [[1][Tier-1] [,] [Tier-2] [,] [and] [Tier-3] [,] [and] [Tier-4]] Prescription Drug Products [[2]at a Network Pharmacy] [[3]at a non-Network Pharmacy] [[4]at a Network or non-Network Pharmacy] [in a year before we begin paying for Prescription Drug Products.]	[$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]
[1]Include when preventive medications are not subject to the Annual Drug Deductible. [2]Include when either [3]insulin or [4]diabetic supplies or [5]both are not subject to the Annual Drug Deductible.	*The options below correspond with Option 2.*
[[1]Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.]	*Include appropriate Tiers based on plan design. Insert deductible amounts or no deductible option according to benefit design chosen by group. Remove any Tiers that are not a part of the plan design.*
[[2]Benefits for [[3]insulin] [[5]or] [[4]diabetic supplies] are not subject to payment of the Annual Drug Deductible.]	***[Tier-1]***
Include if the benefit plan has Annual Drug Deductible carry over provision.	[No Annual Drug Deductible.]
[1]Include when carry-over feature applies only to the individual portion of the Annual Drug Deductible.	*Include when individual Tier-1 Deductible applies.*
[Any amount you pay that is applied to the Annual Drug Deductible in the last quarter of the previous [calendar] [Policy] year will be carried over and	[$[XX – XX] per Covered Person.]
	Include when individual (with family maximum) Tier-1 Deductible applies.
	[$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]
	[Tier-2]
	[No Annual Drug Deductible.]
	Include when individual Tier-2 Deductible applies.
	[$[XX – XX] per Covered Person.]
	Include when individual (with family maximum) Tier-2 Deductible applies.
	[$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]
	[Tiers 1 and 2]
	[No Annual Drug Deductible.]
	Include when individual Tiers 1 and 2 Deductible applies.
	[$[XX – XX] per Covered Person.]
	Include when individual (with family maximum) Annual Drug Deductible applies.
	[$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]
	[Tier-3]
	[No Annual Drug Deductible.]
	Include when individual Tier-3 Deductible applies.
	[$[XX – XX] per Covered Person.]
	Include when individual (with family maximum) Tier-3 Deductible applies.
	[$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all

Payment Term And Description	Amounts
applied to the current Annual Drug Deductible. [[1]This carry-over feature applies only to the individual Annual Drug Deductible.]] *Include if the benefit plan has a roll over provision and applies to the 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 drug deductible provision of the prior policy will apply to the Annual Drug Deductible provision under the Policy.] *Include if the roll-over provision applies to a group changing from a calendar year to Policy year plan. [1]Include when this applies only to the individual portion of the Annual Drug Deductible.* [When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for Prescription Drug Product expenses in the last three months of the previous calendar year that is applied to the previous Annual Drug Deductible, will be rolled over and applied to the current Policy year Annual Drug Deductible. This roll-over feature applies only to the first Policy year. [[1]This roll-over feature applies only to the individual Annual Drug Deductible.]]	Covered Persons in a family.] ***[Tier-4]*** [No Annual Drug Deductible.] *Include when individual Tier-4 Deductible applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) Tier-4 Deductible applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] ***[Tiers 3 and 4]*** [No Annual Drug Deductible.] *Include when individual Tiers 3 and 4 Deductible applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) Tiers 3 and 4 Deductible applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]
[Out-of-Pocket Drug Maximum]	
Include text if Copayments and/or Coinsurance are limited by the Out-of-Pocket Drug Maximum. Select either separate statement for Network Benefits and Non-Network Benefits (and delete the combined choice) or select the combined option (and delete the separate Network/Non-Network choices). *[1]Include if OOPDM includes Copayments.[2]Include for plans with Copayment and Coinsurance options and the OOPDM does not include Copayments.* [The maximum amount you are required	*Insert maximum amounts according to benefit design chosen by group.* *[1]Include if Copayments and Coinsurance are not subject to an Out-of-Pocket Drug Maximum.* *[2]Include if Copayments and/or Coinsurance are subject to an Out-of-Pocket Drug Maximum and the benefit design includes an Annual Drug Deductible.* *[3]If an Annual Drug Deductible applies, select the appropriate statement about whether or not the Annual Drug Deductible applies to the OOPDM.* [***Network]*** *Include when individual OOPDM applies* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) OOPDM applies.*

Payment Term And Description	Amounts
to pay for covered Prescription Drug Products in a single year. Once you reach the Out-of-Pocket Drug Maximum, you will not be required to pay [[1]Copayments or] Coinsurance for covered Prescription Drug Products for the remainder of the year. [[2]The Out-of-Pocket Drug Maximum does not include Copayments.]] *Include when there is a separate Specialty Prescription Drug Product OOPM.* [Copayments and Coinsurance for covered Specialty Prescription Drug Products are not limited by the Out-of-Pocket Drug Maximum.] *Include when Infertility is mandated and Copayments and Coinsurance for Infertility drugs do not apply to the OOPDM.* [Copayments and Coinsurance for covered Prescription Drug Products for Infertility are not limited by the Out-of-Pocket Drug Maximum.]	[$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] [[1]Copayments and Coinsurance for Prescription Drug Products are not limited by an Out-of-Pocket Drug Maximum.] [[2]The Out-of-Pocket Drug Maximum [[3]includes] [[3]does not include] the Annual Drug Deductible.] [***Non-Network]*** *Include when individual OOPDM applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) OOPDM applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] [[1]Copayments and Coinsurance for Prescription Drug Products are not limited by an Out-of-Pocket Drug Maximum.] [[2]The Out-of-Pocket Drug Maximum [[3]includes] [[3]does not include] the Annual Drug Deductible.] [***Network and Non-Network]*** *Include when individual OOPDM applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) OOPDM applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] [[2]The Out-of-Pocket Drug Maximum [[3]includes] [[3]does not include] the Annual Drug Deductible.]
Include when there is a separate SOOPDM. **[Specialty Prescription Drug Product Out-of-Pocket Maximum]**	
Include text if Copayments and/or Coinsurance are limited by the Specialty Prescription Drug Product Out-of-Pocket Maximum. [1]Include if SOOPM includes Copayments.[2]Include for plans with Copayment and Coinsurance options and the SOOPM does not include Copayments. [The maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single year. Once you reach the Specialty Prescription Drug Product Out-of-Pocket Maximum, you will not be required to pay [[1]Copayments or] Coinsurance for	*Insert maximum amounts according to benefit design chosen by group.* *[1]Include when a separate Specialty Prescription Drug Product Out-of-Pocket Maximum applies per Therapeutic Class.* *[2]Include if Copayments and/or Coinsurance are subject to a Specialty Prescription Drug Product Out-of-Pocket Maximum and the benefit design includes a Specialty Prescription Drug Product Annual Deductible.* *[3]If a Specialty Prescription Drug Product Annual Deductible applies, select the appropriate statement about whether or not the Specialty Prescription Drug Product Annual Deductible applies to the Specialty Prescription Drug Product Out-of-Pocket Maximum.* *[4]Include if Copayments and Coinsurance are not subject to a Specialty Prescription Drug Product Out-of-Pocket Maximum.*

Payment Term And Description	Amounts
covered Specialty Prescription Drug Products for the remainder of the year. [[2]The Specialty Prescription Drug Product Out-of-Pocket Maximum does not include Copayments.]]	*Include for groups that purchase Specialty pharmacy and an SOOPM applies separately to all Specialty Prescription Drug Products.*
	[***Specialty Prescription Drug Product]***
	Include when individual SOOPM applies.
Include when Infertility is mandated and Copayments and Coinsurance for Infertility drugs do not apply to the SOOPM. Standard is to include.	[$[XX – XX] for Specialty Prescription Drug Products per Covered Person per year.] [[1]This does not include any maximum stated below.]
	Include when individual (with family maximum) SOOPM applies.
[Copayments and Coinsurance for covered Specialty Prescription Drug Products for Infertility are not limited by the Specialty Prescription Drug Product Out-of-Pocket Maximum.]	[$[XX – XX] for Specialty Prescription Drug Products per Covered Person per year, not to exceed $[XX – XX] for all Covered Persons in a family.] [[1]This does not include any maximum stated below.]
	[[2]This Specialty Prescription Drug Product Out-of-Pocket Maximum [[3]includes] [[3]does not include] the Specialty Prescription Drug Product Annual Deductible.]
	[[4]Copayments and Coinsurance for covered Specialty Prescription Drug Products are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.]
	Include for groups that purchase Specialty pharmacy and SOOPM applies per Specialty Prescription Drug Product.
	[***Specialty - Per Specialty Prescription Drug Product]***
	Include when individual SOOPM per product applies.
	[$[XX – XX] per Specialty Prescription Drug Product per Covered Person.] [[1]This does not include any maximum stated below.]
	Include when individual (with family maximum) SOOPM per product applies.
	[$[XX – XX] per Specialty Prescription Drug Product per Covered Person per year, not to exceed $[XX – XX] per Specialty Prescription Drug Product for all Covered Persons in a family.] [[1]This does not include any maximum stated below.]
	[[2]This Specialty Prescription Drug Product Out-of-Pocket Maximum [[3]includes] [[3]does not include] the Specialty Prescription Drug Product Annual Deductible.]
	Include the paragraphs below if the Specialty Out-of-Pocket Maximum applies per Therapeutic Class and include the applicable SOOPM amount or no SOOPM based on plan design.
	[***Specialty - per Therapeutic Class]***
	Include when individual SOOPM per Therapeutic Class A applies
	[$[XX – XX] for Specialty Prescription Drug Products in Therapeutic Class A per Covered Person.]
	Include when individual (with family maximum) SOOPM per Therapeutic Class A applies.
	[$[XX – XX] for Specialty Prescription Drug Products in Therapeutic Class A per Covered Person, not to exceed $[XX – XX] for all Covered

Payment Term And Description	Amounts
	Persons in a family.] [[4]Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class A are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] [[2]This Specialty Prescription Drug Product Out-of-Pocket Maximum [[3]includes] [[3]does not include] the Specialty Prescription Drug Product Annual Deductible.] *Include when individual SOOPM per Therapeutic Class B applies.* [$[XX – XX] for Specialty Prescription Drug Products in Therapeutic Class B per Covered Person.] *Include when individual (with family maximum) SOOPM per Therapeutic Class B applies.* [$[XX – XX] for Specialty Prescription Drug Products in Therapeutic Class B per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] [[4]Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class B are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] [[2]This Specialty Prescription Drug Product Out-of-Pocket Maximum [[3]includes] [[3]does not include] the Specialty Prescription Drug Product Annual Deductible.] *Include when individual SOOPM per Therapeutic Class C applies.* [$[XX – XX] for Specialty Prescription Drug Products in Therapeutic Class C per Covered Person.] *Include when individual (with family maximum) SOOPM per Therapeutic Class C applies.* [$[XX – XX] for Specialty Prescription Drug Products in Therapeutic Class C per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] [[4]Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class C are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] [[2]This Specialty Prescription Drug Product Out-of-Pocket Maximum [[3]includes] [[3]does not include] the Specialty Prescription Drug Product Annual Deductible.]
[Annual Maximum Drug Benefit] *Include text if there is an Annual Maximum Drug Benefit.* [The maximum amount we will pay for covered Prescription Drug Products during the year.]	*Choose separate maximum for Network and Non-Network Benefits or a combined maximum, depending on plan design.* *Insert maximum amounts according to benefit design chosen by group.* [***Network]*** [$[XX - XX] per Covered Person.] *Insert maximum amounts according to benefit design chosen by group.*

Payment Term And Description	Amounts
	[***Non-Network***] [$[XX - XX] per Covered Person.] *Insert maximum amounts according to benefit design chosen by group.* [***Network and Non-Network***] [$[XX - XX] per Covered Person.]
Contract Specialist - Only include this option if your state mandates coverage for Infertility and allows an annual maximum. **[Infertility Annual Maximum Benefit]**	
Include text if there is an Infertility Annual Maximum Benefit. [The maximum amount we will pay for covered Prescription Drug Products for Infertility during a year.] *Include if there is an overall Annual Maximum Drug Benefit in this Rider.* [The Infertility Annual Maximum Benefit is included in the overall Annual Maximum Drug Benefit stated above.]	*Insert maximum amounts according to benefit design chosen by group.* *Standard is $7,000 per Covered Person.* [$[XX - XX] per Covered Person.]
Contract Specialist - Only include this option if your state mandates coverage for Infertility and a separate Infertility Maximum Policy Benefit is allowed. **[Infertility Maximum Policy Benefit]**	
Include text if there is an Infertility Maximum Policy Benefit and an Infertility Benefit is included in the Medical coverage. [The maximum amount we will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Policy.]	*Include when there is a Maximum Policy Benefit for Infertility drugs.* *Insert maximum amounts according to benefit design chosen by group. Standard is $7,000 per Covered Person.* [$[XX - XX] per Covered Person.]
[Specialty Prescription Drug Product Maximum Policy Benefit]	
Include text if there is a Specialty Prescription Drug Product Maximum Policy Benefit. [The maximum amount we will pay for covered Specialty Prescription Drug Products during the entire period of time you are enrolled for coverage under the	*Include when there is a Maximum Policy Benefit for Specialty Prescription drugs.* *Insert maximum amounts according to benefit design chosen by group.* [$[XX - XX] per Covered Person.]

Payment Term And Description	Amounts
Policy.]	
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network or non-Network Pharmacy is a specific dollar amount. ***Coinsurance*** Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Cost. Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate. ***Copayment and Coinsurance*** Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. *Include when programs are available for enhanced benefits.* *[1]Include when notification is required.* *[2]Include when prior authorization is required.* [Your Copayment and/or Coinsurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable [[1]notification] [[2]prior authorization], participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication regimens. You may access	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance or • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. *Include for groups that purchase the mail order pharmacy benefit.* [For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance or • The Prescription Drug Cost for that Prescription Drug Product.] See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts.

Payment Term And Description	Amounts
information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Include when plan includes Specialty Drug Program. **[Specialty Prescription Drug Products]**	
[The following supply limits apply. • As written by the provider, up to a consecutive [31] [60]-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive [31]-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. *[1]Include commas and "or" as required to accommodate plan design. [2] Include when plan design includes mail order pharmacy benefits. [3]Include when plan design includes Designated Pharmacy.* Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy [[1],] [[1]or] a non-Network Pharmacy [[1],] [[1]or] [[2]a mail order Network Pharmacy] [[1]or] [[3]a Designated Pharmacy].	*Benefits are provided for either a 2-Tier, 3-Tier,or 4-Tier Benefit. [1]Delete comma and include "or" when benefit design is 2 Tier. Include comma and delete "or" when benefit design is 3 Tier or more. [2] Delete comma and include "or" when benefit design is 3 Tier. [3] Delete comma and include "or" when benefit design is 4 Tier.* *[4]Always include introductory paragraph and Copayment and Coinsurance statements unless the Plan Design has a combined medical/RX Annual Deductible equal to the combined medical/RX OOPM, in which case delete the introductory paragraph and all tiered Copayment and Coinsurance options and choose [5]"No Copayment."* [[4]Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3] or] [Tier-4]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] ***[Network Pharmacy]*** *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance per Therapeutic Class. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B, and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Specialty Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited*

Description and Supply Limits	Benefit (The Amount We Pay)
	by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-1 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance per Therapeutic Class. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B, and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-2 Specialty Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-2 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below only if the benefit design is 3 Tier or more.
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance per Therapeutic Class. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B, and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.

Description and Supply Limits	Benefit (The Amount We Pay)
	[For a Tier-3 Specialty Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 4 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance per Therapeutic Class. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B, and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Specialty Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount.*

Description and Supply Limits	Benefit (The Amount We Pay)
	Choose appropriate combination per plan design. [For a Tier-4 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] [[5]No Copayment] ***[Non-Network Pharmacy]*** *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance per Therapeutic Class. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B, and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Specialty Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance per Therapeutic Class. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B, and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose*

Description and Supply Limits	Benefit (The Amount We Pay)
	appropriate combination per plan design. [For a Tier-2 Specialty Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 3 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance per Therapeutic Class. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B, and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Specialty Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]

Description and Supply Limits	Benefit (The Amount We Pay)
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design. [For a Tier-3 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below if the benefit design is 4 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance per Therapeutic Class. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B, and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Specialty Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] [[5]No Copayment] *Include when Closed Benefit Plan applies* *[1]Delete comma and include "or" when there is a closed benefit plan with*

Description and Supply Limits	Benefit (The Amount We Pay)
	2 Tiers (Closed Benefit Plan). Include comma and delete "or" when closed benefit plan is 3 Tier. [2] Delete comma and include "or" when Closed benefit is 3 Tier. [Specialty Prescription Drug Products that are not on Tier-1 [1,] [1or] [Tier-2] [2,] [2or] [Tier-3] of the Prescription Drug List are not covered.]
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. *[1]Include for groups that purchase the mail order benefit* • [[1]If the Network Pharmacy agrees to provide the same services or products for the same terms as the mail order Network Pharmacy, you may obtain up to a consecutive 90-day supply of a Prescription Drug Product.] *[2]Remove for religious employers who choose to exclude contraceptive coverage.* • [[2]A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied.] When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. *[1]Include when plan design includes Preferred Retail Network Pharmacy and Copayments and/or Coinsurance are reduced for Prescription Drug Products obtained at a Preferred pharmacy. Select Copayment and Coinsurance options depending on plan design.* *[2]Include when plan design includes*	*Benefits are provided for either 2-Tier, 3-Tier, or 4-Tier Benefit. [1]Delete comma and include "or" when benefit design is 2 Tier. Include comma and delete "or" when benefit design is 3 Tier or more. [2] Delete comma and include "or" when benefit design is 3 Tier. Include comma and delete "or" when benefit design is 4 Tier or more. [3] Delete comma and include "or" when benefit design is 4 Tier.* *[5]Always include introductory paragraph and Copayment and Coinsurance statements unless the Plan Design has a combined medical/RX Annual Deductible equal to the combined medical/RX OOPM, in which case delete the introductory paragraph and all tiered Copayment and Coinsurance options and choose [4]"No Copayment".* [[5]Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1 [1,] [1or] [Tier-2] [2,] [2or] [Tier-3] [3,] [3 or] [Tier-4]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product: [___]% of the Prescription Drug Cost [1after you pay a Copayment of $[___]] per Prescription Order or Refill [2, except that we pay [3[__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [1after you pay a Copayment of $[___]]] [4,] [5and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [1after you pay a Copayment of $[___]]] [6, and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [1after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [7[However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount.*

Description and Supply Limits	Benefit (The Amount We Pay)
Preferred Retail Network Pharmacy and Copayments and/or Coinsurance are increased when Prescription Drug Products are obtained at a non-Preferred pharmacy. Select Copayment and Coinsurance options depending on plan design. [[1]If you use a Preferred Retail Network Pharmacy, your Copayment will be reduced by [$XX] per Prescription Order or Refill.] [[1]If you use a Preferred Retail Network Pharmacy, your Coinsurance will be reduced by [__]% of the Prescription Drug Cost per Prescription Order or Refill.] [[2]If you use a Non-Preferred Retail Network Pharmacy, your Copayment will be increased by [$XX] per Prescription Order or Refill.] [[2]If you use a Non-Preferred Retail Network Pharmacy, your Coinsurance will be increased by [__]% of the Prescription Drug Cost per Prescription Order or Refill.]	*Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 3 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or

Description and Supply Limits	Benefit (The Amount We Pay)
	Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-3 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below only if the benefit design is 4 Tier or more. *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.*
	[For a Tier-4 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-4 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a

Description and Supply Limits	Benefit (The Amount We Pay)
	Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] [[4]No Copayment] *Include when plan design includes some level of closed benefit plan.* *[1]Delete comma and include "or" when there is a closed benefit plan with 2 Tiers (Closed Benefit Plan). [2] Include "or" when Closed benefit is 3 Tier.* [Prescription Drug Products that are not on Tier-1 [[1],] [[1]or] [Tier-2] [[2]or] [Tier-3] of the Prescription Drug List are not covered.]
Prescription Drugs from a Retail Non-Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. *[1]Remove for religious employers who choose to exclude contraceptive coverage.* • [[1]A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied.] When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	*Benefits are provided for either a 2-Tier, 3-Tier, or 4-Tier. [1]Delete comma and include "or" when benefit design is 2 Tier. Include comma and delete "or" when benefit design is 3 Tier or more. [2] Delete comma and include "or" when benefit design is 3 Tier. Include comma and delete "or" when benefit design is 4 Tier or more. [3] Delete comma and include "or" when benefit design is 4 Tier.* *[5]Always include introductory paragraph and Copayment and Coinsurance statements unless the Plan Design has a combined medical/RX Annual Deductible equal to the combined medical/RX OOPM, in which case delete the introductory paragraph and all tiered Copayment and Coinsurance options and choose.4[6]"No Copayment."* [[5]Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3] or] [Tier-4]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a

Description and Supply Limits	Benefit (The Amount We Pay)
	Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-1 Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-2 Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-2 Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below only if the benefit design is 3 Tier or more.

Description and Supply Limits	Benefit (The Amount We Pay)
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design. [For a Tier-3 Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 4 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a

Description and Supply Limits	Benefit (The Amount We Pay)
	Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] [[4]No Copayment] *Include when plan includes some level of closed benefit plan* *[1]Delete comma and include "or" when there is a closed benefit plan with 2 Tiers (Closed Benefit Plan). Include comma and delete "or" when closed benefit plan is 3 Tier or more. [2] Include "or" when Closed benefit is 3 Tier.* [Prescription Drug Products that are not on Tier-1 [[1],] [[1]or] [Tier-2] [[2]or] [Tier-3] of the Prescription Drug List are not covered.]
Include for groups that purchase the mail order benefit. **[Prescription Drug Products from a Mail Order Network Pharmacy]**	
[The following supply limits apply: *[1]Include if benefit plan design includes specialty drug program.* *[2]Include if benefit plan design includes the List of Preventive Medications.* • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. [[1]These supply limits do not apply to Specialty Prescription Drug Products[[2], including Specialty Prescription Drug Products on the List of Preventive Medications]. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to	*Benefits are provided for either a 2-Tier, 3-Tier, or 4-Tier. [1]Delete comma and include "or" when benefit design is 2 Tier. Include comma and delete "or" when benefit design is 3 Tier or more. [2] Delete comma and include "or" when benefit design is 3 Tier. [3] Include when benefit design is 4 Tier.* *[5]Always include introductory paragraph and Copayment and/or Coinsurance statements unless the Plan Design has a combined medical/RX Annual Deductible equal to the combined medical/RX OOPM, in which case delete the introductory paragraph and all tiered Copayment and Coinsurance options and choose [4]"No Copayment."* [[5]Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3] or Tier-4]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] *There are two Copayment and/or Coinsurance options. The first is to tie the number of days' supply to the Copayment and/or Coinsurance level at 31 days, 60 days and 90 days. The second option is to apply a*

Description and Supply Limits	Benefit (The Amount We Pay)
the supply limits stated above under the heading *Specialty Prescription Drug Products*.] *Include if coverage is initially required at a retail pharmacy prior to using mail order.* [You may be required to fill an initial Prescription Drug Product order and obtain [1 - 3] refill[s] through a retail pharmacy prior to using a mail order Network Pharmacy.] *Include the following paragraph only when mail order Copayments and/or Coinsurance in the right hand column are charged for the full 90 day supply. Delete if Copayments and/or Coinsurance are tied to the 31, 60 and 90 day supply.* [To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.]	*Copayment and/or Coinsurance, calculated only at the 90-day level, for any number of days' supply of mail order drugs.* *Include text when Copayments and/or Coinsurance are tied to a number-of-days' supply. Delete if a single Copayment and/or Coinsurance applies to any supply of mail order drugs.* [For up to a 31-day supply, we pay:] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a

Description and Supply Limits	Benefit (The Amount We Pay)
	Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 3 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will

Description and Supply Limits	Benefit (The Amount We Pay)
	not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below only if the benefit design is 4 Tier.
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-4 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-4 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include following paragraphs (describing a 60-day supply limit) only when Copayments and/or Coinsurance are tied to days' supply. Delete if a single Copayment and/or Coinsurance applies to any supply of mail order drugs.
	[For up to a 60-day supply, we pay:]
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-1 Prescription Drug Product: [___]% of the Prescription Drug

Description and Supply Limits	Benefit (The Amount We Pay)
	Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you

Description and Supply Limits	Benefit (The Amount We Pay)
	will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below only if the benefit design is 3 Tier or more.
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-3 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-3 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below only if the benefit design is 4 Tier.
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-4 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for

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	a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include following paragraphs describing a 90-day supply limit only when Copayments and/or Coinsurance are tied to days' supply. Delete if a single Copayment and/or Coinsurance applies to any supply of mail order drugs.* [For up to a 90-day supply, we pay:] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product on the List of Preventive

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	Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below if the benefit design is 3 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a

Description and Supply Limits	Benefit (The Amount We Pay)
	Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below if the benefit design is 4 Tier.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will

Description and Supply Limits	Benefit (The Amount We Pay)
	not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] [[4]No Copayment] *Include when plan includes some level of closed benefit plan* *[1]Delete comma and include "or" when there is a closed benefit plan with 2 Tiers (Closed Benefit Plan). [2] Include "or" when Closed benefit is 3 Tier.* [Prescription Drug Products that are not on Tier-1 [[1],] [[1]or] [Tier-2] [[2]or] [Tier-3] of the Prescription Drug List are not covered.]

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Include for groups that purchase closed-panel benefits and the corresponding exclusion is included in Section 2. (Closed panel means that we pay only for drugs that are prescribed by a Network provider.)

[Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

Contraceptives are mandated in AR, except for religious group employers. [1]Remove for religious employers who choose to exclude contraceptive coverage.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service[[1] or is prescribed to prevent conception].

If a Brand-name Drug Becomes Available as a Generic

Include for groups that purchase an Open Benefit Design.

[1]Include for groups that purchase the Mandatory or Restrictive Program.

[If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change [[1]and an Ancillary Charge may apply]. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.]

Include for groups that purchase a closed benefit design.

[1]Include for group that purchase the Mandatory or Restrictive Program.

[If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change [[1]and an Ancillary Charge may apply,] or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.]

Include for groups that purchase closed-panel benefits and the corresponding exclusion is included. (Closed panel means that we pay only for drugs that are prescribed by a Network provider.)

[Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

[1]Include when notification is required.

[2]Include when prior authorization is required.

[[1]Notification] [[2]Prior Authorization] Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to [[1]notify] [[2]obtain prior authorization from] us or our designee. The reason for [[1]notifying] [[2]obtaining prior authorization from] us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not an Experimental or Investigational or Unproven Service.

Network Pharmacy [[1]Notification] [[2]Prior Authorization]

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for [[1]notifying] [[2]obtaining prior authorization from] us.

Non-Network Pharmacy [[1]Notification] [[2]Prior Authorization]

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for [[1]notifying] [[2]obtaining prior authorization from] us as required.

If [[1]we are not notified] [[2]you do not obtain prior authorization from us] before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring [[1]notification] [[2]prior authorization] are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires [[1]notification] [[2]prior authorization] through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

If [[1]we are not notified] [[2]you do not obtain prior authorization from us] before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Cost) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

[3]Include for groups that purchase the Mandatory or Restrictive Generic Program.

[4]Include when benefit plan design includes Therapeutic Class Charge.

When you submit a claim on this basis, you may pay more because you did not [[1]notify] [[2]obtain prior authorization from] us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance [[3], Ancillary Charge] [[4], Therapeutic Class Charge] and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

Include when programs which result in enhanced Benefits are available.

[We may also require [[1]notification] [[2]prior authorization] for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable [[1]notification] [[2]prior

authorization], participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

Include when step therapy requirements apply.

[Step Therapy]

[Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products for which Benefits are described in your *Certificate* are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

What You Must Pay

[1]Include if the benefit plan design has an Annual Drug Deductible. [2]Include if the benefit plan design has an Annual Drug Deductible and a Specialty Prescription Drug Product Annual Deductible. [3]Include when the benefit plan design has a Specialty Prescription Drug Product Annual Deductible.

[You are responsible for paying the [[1]Annual Drug Deductible] [[2]and] [[3] Specialty Prescription Drug Product Annual Deductible].]

[1]Include when preventive medications are not subject to the Annual Drug Deductible. [2]Include when either [3]insulin or [4]diabetic supplies or [5]both are not subject to the Annual Drug Deductible.

[[1]Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.]

[[2]Benefits for [[3]insulin] [[5]or] [[4]diabetic supplies] are not subject to payment of the Annual Drug Deductible.]

Include when benefit plan has combined medical/RX deductible. When this applies, references to Annual Drug Deductible in this Rider should never be included.

[You are responsible for paying the Annual Deductible stated in the *Schedule of Benefits* which is attached to your *Certificate* before Benefits for Prescription Drug Products under this Rider are available to you.]

[1]Include when preventive medications are not subject to the Annual Deductible. [2]Include when either [3]insulin or [4]diabetic supplies or [5]both are not subject to the Annual Deductible.

[[1]Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Deductible.]

[[2]Benefits for [[3]insulin] [[5]or] [[4]diabetic supplies] are not subject to payment of the Annual Deductible.]

[1]Include for groups that purchase the Mandatory or Restrictive Generic Program. [2]Include when the benefit plan design includes Therapeutic Class Charge. [3]Include when #1 is removed. [4]Include when #1 remains.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table [[1], in addition to any Ancillary Charge] [[2][[3], in addition to any] [[4]or] Therapeutic Class Charge].

Include for groups that purchase the Mandatory or Restrictive Generic Program.

[1]Include for groups that purchase the Mandatory Generic Program. [2]Include when the lower tiered drug Copayment and/or Coinsurance applies. [3]Include when the higher tiered drug Copayment and/or Coinsurance applies. [4]Include for CDHPs, HSAs and HRAs if plan design has a deductible/OOPDM provision. Include the appropriate deductible provisions and OOPDM provisions based on plan design.

[An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your [[1]or the provider's] request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the [[2]lower tiered drug] [[3]higher tier drug]. [[4]An Ancillary Charge does not apply to any [Annual Drug Deductible] [,] [Specialty Prescription Drug Product Annual Deductible] [,] [or] [Out-of-Pocket Drug Maximum] [or] [Specialty Prescription Drug Product Out-of-Pocket Maximum].]]

Include when benefit plan design includes Therapeutic Class Charge.

[A Therapeutic Class Charge may apply when the Prescription Drug Cost or the Predominant Reimbursement Rate of the Prescription Drug Product exceeds the maximum amount we allow for a drug in the Prescription Drug Product's Therapeutic Class. You are responsible for the Therapeutic Class Charge and any applicable Copayment and/or Coinsurance.]

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in your *Certificate*:

Include when Copayments are NOT applied to the overall OOPM in the COC. [1]Include when benefit plan design includes Specialty Drug Copayments.

- [Copayments for Prescription Drug Products [[1], including Specialty Prescription Drug Products].]

Include when Coinsurance is NOT applied to the overall OOPM in the COC. [1]Include when benefit plan design includes Specialty Drug Coinsurance.

- [Coinsurance for Prescription Drug Products [[1], including Specialty Prescription Drug Products].]

Include for groups that purchase the Mandatory or Restrictive Generic Program.

- [Ancillary Charges.]

Include when benefit plan design includes Therapeutic Class Charge.

- [Therapeutic Class Charges.]

Include if the Annual Drug Deductible provision applies, however delete if the Annual Drug Deductible is included in the Annual Deductible in the Medical COC and the OOPM in the COC includes the Annual Deductible.

- [The Annual Drug Deductible.]

Include if the Specialty Prescription Drug Product Annual Deductible provision applies, however delete if the Specialty Annual Deductible is included in the Annual Deductible in the Medical COC and the OOPM in the COC includes the Annual Deductible.

- [The Specialty Prescription Drug Product Annual Deductible.]

Include if the Annual Maximum Drug Benefit applies.

- [Any amount you pay for Prescription Drug Products that exceeds the Annual Maximum Drug Benefit.]

Include if the Specialty Prescription Drug Product Annual Maximum Benefit applies.

- [Any amount you pay for Specialty Prescription Drug Products that exceeds the Specialty Prescription Drug Product Annual Maximum Benefit.]

Include if the Infertility Annual Maximum Benefit applies.

- [Any amount you pay for Prescription Drug Products for Infertility that exceeds the Infertility Annual Maximum Benefit.]

Include if Infertility Maximum Policy Benefit applies.

- [Any amount you pay for Prescription Drug Products for Infertility that exceeds the Infertility Maximum Policy Benefit.]
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Cost) will not be available to you.

Payment Information

If group purchases a plan design with an Annual Drug Deductible provision, retain the Annual Drug Deductible provision below per that plan design.

Include Specialty Prescription Drug Product Annual Deductible provision when a separate deductible applies to Specialty Prescription Drug Products.

If group purchases a plan design with an Out-of-Pocket Drug Maximum, include Out-of-Pocket Drug Maximum.

If group purchases a plan design with a Specialty Prescription Drug Product Out-of-Pocket Maximum, include the Specialty Prescription Drug Product Out-of-Pocket Maximum.

If group purchases a plan design with an Annual Maximum Drug Benefit, include Annual Maximum Drug Benefit.

If group purchases a plan design with a Specialty Prescription Drug Product Annual Maximum Benefit, include the Specialty Prescription Drug Product Annual Maximum Benefit.

If there is an Infertility Benefit in the medical coverage, and an Infertility Annual Maximum Benefit applies to Infertility drugs per the plan design, include the Infertility Annual Maximum Benefit.

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

[The Specialty Prescription Drug Product Annual Deductibles are calculated on a [calendar] [Policy] year basis.]

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

[The Specialty Prescription Drug Product Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.]

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

[The Specialty Prescription Drug Product Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

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

Payment Term And Description	Amounts
[Annual Drug Deductible]	
Select either Option 1 or Option 2, if there is an Annual Drug Deductible. *Option 1: Include the following paragraph and corresponding deductible language if application of the Annual Drug Deductible is determined based on Network or Non-Network status.* *[1]Include if the Annual Drug Deductible provision applies only to Tier-2, Tier-3, Tier-4, Tier-5 and/or Tier-6 Prescription Drug Products. (Include commas and "ands" as applicable to the number of tiers covered under this rider.) [2]Include if the Annual Drug Deductible applies only to Network Benefits. [3]Include if the Annual Drug Deductible applies only to*	*The option below corresponds with Option 1.* *Insert deductible amounts according to benefit design chosen by group.* ***[[2]Network]*** [No Annual Drug Deductible.] *Include when individual Annual Drug Deductible applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) Annual Drug Deductible applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] ***[[3]Non-Network]*** [No Annual Drug Deductible.]

Payment Term And Description	Amounts
Non-Network Benefits. [4] Include if the Annual Drug Deductible applies to both Network and Non-Network Benefits. Select options in table accordingly.	*Include when individual Annual Drug Deductible applies.*
[The amount you pay for covered [[1][Tier-2] [,] [and] [Tier-3] [,] [and] [Tier-4] [,] [and] [Tier-5] [, and Tier-6]] Prescription Drug Products [[2]at a Network Pharmacy] [[3]at a non-Network Pharmacy] [[4]at a Network or non-Network Pharmacy] in a year before we begin paying for Prescription Drug Products.]	[$[XX – XX] per Covered Person.]
	Include when individual (with family maximum) Annual Drug Deductible applies.
	[$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]
	[[4]Network and Non-Network]
Option 2: Include the following paragraph and corresponding deductible language when the application of the Annual Drug Deductible is determined based on tier status.	*Include when individual Annual Drug Deductible applies.*
[1]Include the tiers that the Annual Drug Deductible provision applies to: Tier-1, Tier-2, Tier-3, Tier-4, Tier-5 and/or Tier-6 Prescription Drug Products. (Include commas and "ands" as applicable to the number of tiers covered under this Rider.) [2]Include if the Annual Drug Deductible applies only to Network Benefits. [3]Include if the Annual Drug Deductible applies only to Non-Network Benefits. [4] Include if the Annual Drug Deductible applies to both Network and Non-Network Benefits.	[$[XX – XX] per Covered Person.]
	Include when individual (with family maximum) Annual Drug Deductible applies.
	[$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]
	The options below correspond with Option 2.
	Include appropriate Tiers based on plan design. Insert deductible amounts or no deductible option according to benefit design chosen by group. Remove any Tiers that are not a part of the plan design.
	[Tier-1]
[The amount you pay for covered [[1][Tier-1] [,] [Tier-2] [,] [and] [Tier-3] [,] [and] [Tier-4] [,] [and] [Tier-5] [, and] [Tier-6]] Prescription Drug Products [[2]at a Network Pharmacy] [[3]at a non-Network Pharmacy] [[4]at a Network or non-Network Pharmacy] in a year before we begin paying for Prescription Drug Products.]	[No Annual Drug Deductible.]
	Include when individual Tier-1 Deductible applies.
	[$[XX – XX] per Covered Person.]
	Include when individual (with family maximum) Tier-1 Deductible applies.
	[$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]
	[Tier-2]
	[No Annual Drug Deductible.]
	Include when individual Tier-2 Deductible applies.
	[$[XX – XX] per Covered Person.]
	Include when individual (with family maximum) Tier-2 Deductible applies.
	[$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]
[1]Include when preventive medications are not subject to the Annual Drug Deductible. [2]Include when either [3]insulin or [4]diabetic supplies or [5]both are not subject to the Annual Drug Deductible.	***[Tiers 1 and 2]***
[[1]Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.]	[No Annual Drug Deductible.]
	Include when individual Tiers 1 and 2 Deductible applies.
	[$[XX – XX] per Covered Person.]
	Include when individual (with family maximum) Annual Drug Deductible applies.
	[$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all

Payment Term And Description	Amounts
[[2]Benefits for [[3]insulin] [[5]or] [[4]diabetic supplies] are not subject to payment of the Annual Drug Deductible.] *Include if the benefit plan has Annual Drug Deductible carry over provision.* *[1]Include when carry-over feature applies only to the individual portion of the Annual Drug Deductible.* [Any amount you pay that is applied to the Annual Drug Deductible in the last quarter of the previous [calendar] [Policy] year will be carried over and applied to the current Annual Drug Deductible. [[1]This carry-over feature applies only to the individual Annual Drug Deductible.]] *Include if the benefit plan has a roll over provision and applies to the 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 drug deductible provision of the prior policy will apply to the Annual Drug Deductible provision under the Policy.] *Include if the roll-over provision applies to a group changing from a calendar year to Policy year plan. [1]Include when this applies only to the individual portion of the Annual Drug Deductible.* [When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for Prescription Drug Product expenses in the last three months of the previous calendar year that is applied to the previous Annual Drug Deductible, will be rolled over and applied to the current Policy year Annual Drug Deductible. This roll-over feature applies only to the first Policy year. [[1]This roll-over feature applies only to the individual Annual Drug Deductible.]]	Covered Persons in a family.] ***[Tier-3]*** [No Annual Drug Deductible.] *Include when individual Tier-3 Deductible applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) Tier-3 Deductible applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] ***[Tier-4]*** [No Annual Drug Deductible.] *Include when individual Tier-4 Deductible applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) Tier-4 Deductible applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] ***[Tiers 3 and 4]*** [No Annual Drug Deductible.] *Include when individual Tiers 3 and 4 Deductible applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) Tiers 3 and 4 Deductible applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] ***[Tier-5]*** [No Annual Drug Deductible.] *Include when individual Tier-5 Deductible applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) Tier-5 Deductible applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] ***[Tier-6]*** [No Annual Drug Deductible.] *Include when individual Tier-6 Deductible applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) Tier-6 Deductible applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]

Payment Term And Description	Amounts
	[Tiers 5 and 6] [No Annual Drug Deductible.] *Include when individual Tiers 5 and 6 Deductible applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) Tiers 5 and 6 Deductible applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]
[Specialty Prescription Drug Product Annual Deductible]	
Option 1: Include the applicable paragraphs and corresponding deductible language if application of the Specialty Annual Deductible is determined based on Specialty Prescription Drug Product, per Specialty Drug Product, per Therapeutic Class and/or growth hormone therapy. *[1]Include if the Specialty Annual Deductible provision applies only to Tier-2, Tier-3, Tier-4, Tier-5 and/or Tier-6 Prescription Drug Products. (Include commas and "ands" as applicable to the number of tiers covered under this rider.) [2]Include if the Specialty Annual Deductible applies only to Network Benefits. [3]Include if the Specialty Annual Deductible applies only to Non-Network Benefits. [4] Include if the Specialty Annual Deductible applies to both Network and Non-Network Benefits. [5]Include if the Specialty Annual Deductible applies to drugs from a Designated Pharmacy.* [The amount you pay for covered [[1][Tier-2] [,] [and] [Tier-3] [,] [and] [Tier-4] [,] [and] [Tier-5] [, and] [Tier-6]] Specialty Prescription Drug Products [[2]at a Network Pharmacy] [[3]at a non-Network Pharmacy] [[4] at a Network or non-Network Pharmacy] [or] [[5]a Designated Pharmacy] in a year before we begin paying for Specialty Prescription Drug Products.] *Option 2: Include the following paragraph and corresponding deductible language if application of the Specialty*	*The options below correspond with Option 1.* *[1]Include if there is an annual deductible for all Specialty Prescription Drug Products. Include exception language when separate deductibles are included for growth hormone and/or Therapeutic Class. [2]Include if there is an annual deductible Per Specialty Prescription Drug Product. Include exception language when separate deductibles are included for growth hormone and/or Therapeutic Class. [3]Include if there is a separate annual deductible for Specialty Prescription Drug Products - Growth Hormone Therapy.* [[1]***Specialty Prescription Drug Product]*** *Include when individual Specialty Prescription Drug Product Deductible applies.* [$[XX – XX] per Covered Person for Specialty Prescription Drug Products.] [This does not include any deductible stated below.] *Include when individual (with family maximum) Specialty Prescription Drug Product Deductible applies.* [$[XX – XX] per Covered Person for Specialty Prescription Drug Products, not to exceed $[XX – XX] for all Covered Persons in a family.] [This does not include any deductible stated below.] [[2]***Specialty - Per Specialty Prescription Drug Product]*** *Include when individual Per Specialty Prescription Drug Product Deductible applies.* [$[XX – XX] per Specialty Prescription Drug Product per Covered Person.] [This does not include any deductible stated below.] *Include when individual (with family maximum) Per Specialty Prescription Drug Product Deductible applies.* [$[XX – XX] per Specialty Prescription Drug Product per Covered Person, not to exceed $[XX – XX] per Specialty Prescription Drug Product for all Covered Persons in a family.] [This does not include any deductible stated below.] [[3]***Specialty - Growth Hormone Therapy]*** *Include when individual Specialty - Growth Hormone Deductible applies.*

Payment Term And Description	Amounts
Annual Deductible is determined based on tier status. *[1]Include the tiers that the Specialty Annual Deductible provision applies to: Tier-1, Tier-2, Tier-3, Tier-4, Tier-5 and/or Tier-6 Specialty Prescription Drug Products. (Include commas and "ands" as applicable to the number of Tiers covered under this Rider.) [2]Include if the Specialty Annual Drug Deductible applies only to Network Benefits. [3]Include if the Specialty Annual Drug Deductible applies only to Non-Network Benefits. [4] Include if the Specialty Annual Drug Deductible applies to both Network and Non-Network Benefits. [5] Include if the Specialty Annual Drug Deductible applies to drugs from a Designated Pharmacy.*	[$[XX – XX] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person.] *Include when individual (with family maximum) Specialty -Growth Hormone Deductible applies.* [$[XX – XX] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person, not to exceed $[XX – XX] for growth hormone therapy for all Covered Persons in a family.] *Include the paragraphs below if the Specialty Annual Deductible applies per Therapeutic Class and include the applicable deductible amounts or no annual deductible based on plan design.*
[The amount you pay for covered [[1][Tier-1] [,] [Tier-2] [,] [and] [Tier-3] [,] [and] [Tier-4] [,] [and] [Tier-5] [, and] [Tier-6]] Specialty Prescription Drug Products [[2]at a Network Pharmacy] [[3]at a non-Network Pharmacy] [[4]at a Network or non-Network Pharmacy] [or] [[5] a Designated Pharmacy] in a year before we begin paying for Specialty Prescription Drug Products.]	[***Specialty - Per Therapeutic Class]*** [No Specialty Prescription Drug Product Annual Deductible for Therapeutic Class A.] *Include when individual Specialty - Per Therapeutic Class A Deductible applies.* [$[XX – XX] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class A.] *Include when individual (with family maximum) Specialty - Per Therapeutic Class A Deductible applies.* [$[XX – XX] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class A, not to exceed $[XX – XX] for all Covered Persons in a family.] [No Specialty Prescription Drug Product Annual Deductible for Therapeutic Class B.] *Include when individual Specialty - Per Therapeutic Class B Deductible applies.* [$[XX – XX] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class B.] *Include when individual (with family maximum) Specialty - Per Therapeutic Class B Deductible applies.* [$[XX – XX] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class B, not to exceed $[XX – XX] for all Covered Persons in a family.] [No Specialty Prescription Drug Product Annual Deductible for Therapeutic Class C.] *Include when individual Specialty - Per Therapeutic Class C Deductible applies.* [$[XX – XX] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class C.] *Include when individual (with family maximum) Specialty - Per Therapeutic Class C Deductible applies.* [$[XX – XX] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class C, not to exceed $[XX – XX] for all Covered
Include if the benefit plan has deductible carry-over provision. [1]Include when carry-over feature applies only to the individual portion of the Specialty Prescription Drug Product Annual Deductible.	
[Any amount you pay that is applied to the Specialty Prescription Drug Product Annual Deductible in the last quarter of the previous [calendar] [Policy] year will be carried over and applied to the current year's Specialty Prescription Drug Product Annual Deductible. [[1]This carry-over feature applies only to the individual Specialty Prescription Drug Product Annual Deductible.]]	
Include if the benefit plan has a roll-over provision and applies to the group in any circumstance.	
[When a Covered Person was previously covered under a group policy	

Payment Term And Description	Amounts
that was replaced by the group Policy, any amount already applied to that specialty prescription drug product annual deductible provision of the prior policy will apply to the Specialty Prescription Drug Product Annual Deductible provision under the Policy.] *Include if the roll-over provision applies to a group changing from a calendar year to Policy year plan. [1]Include when this applies only to the individual portion of the Specialty Prescription Drug Product Annual Deductible.* [When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for Specialty Prescription Drug Product expenses in the last three months of the previous calendar year that is applied to the previous Specialty Prescription Drug Product Annual Deductible, will be rolled over and applied to the current Policy year Specialty Prescription Drug Product Annual Deductible. This roll-over feature applies only to the first Policy year. [[1]This roll-over feature applies only to the individual Specialty Prescription Drug Product Annual Deductible.]] *Include when an Annual Drug Deductible applies.* [The Specialty Prescription Drug Product Annual Deductible is included in the overall Annual Drug Deductible stated above.]	Persons in a family.] *The options below correspond with Option 2.* *Include appropriate Tiers based on plan design. Insert deductible amounts according to benefit design chosen by group. Remove any Tiers that are not a part of the plan design.* *Insert deductible amounts according to benefit design chosen by group.* [***Tier-1]*** [No Specialty Prescription Drug Product Annual Deductible.] *Include when individual Tier-1 Deductible applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) Tier -1 Deductible applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] [***Tier-2]*** [No Specialty Prescription Drug Product Annual Deductible.] *Include when individual Tier-2 Deductible applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) Tier -2 Deductible applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] [***Tiers 1 and 2]*** [No Specialty Prescription Drug Product Annual Deductible.] *Include when individual Tiers 1 and 2 Deductible applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) Tiers -1 and 2 Deductible applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] [***Tier-3]*** [No Specialty Prescription Drug Product Annual Deductible.] *Include when individual Tier-3 Deductible applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) Tier -3 Deductible applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]

Payment Term And Description	Amounts
	[***Tier-4]***
	[No Specialty Prescription Drug Product Annual Deductible.]
	Include when individual Tier-4 Deductible applies.
	[$[XX – XX] per Covered Person.]
	Include when individual (with family maximum) Tier -4 Deductible applies.
	[$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]
	[***Tiers 3 and 4]***
	[No Specialty Prescription Drug Product Annual Deductible.]
	Include when individual Tiers 3 and 4 Deductible applies.
	[$[XX – XX] per Covered Person.]
	Include when individual (with family maximum) Tiers 3 and 4 Deductible applies.
	[$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]
	[***Tier-5]***
	[No Specialty Prescription Drug Product Annual Deductible.]
	Include when individual Tier-5 Deductible applies.
	[$[XX – XX] per Covered Person.]
	Include when individual (with family maximum) Tier -5 Deductible applies.
	[$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]
	[***Tier-6]***
	[No Specialty Prescription Drug Product Annual Deductible.]
	Include when individual Tier-6 Deductible applies.
	[$[XX – XX] per Covered Person.]
	Include when individual (with family maximum) Tier -6 Deductible applies.
	[$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]
	[***Tiers 5 and 6]***
	[No Specialty Prescription Drug Product Annual Deductible.]
	Include when individual Tiers 5 and 6 Deductible applies.
	[$[XX – XX] per Covered Person.]
	Include when individual (with family maximum) Tiers 5 and 6 Deductible applies.

Payment Term And Description	Amounts
	[$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]
[Out-of-Pocket Drug Maximum]	
Include text if Copayments and/or Coinsurance are limited by the Out-of-Pocket Drug Maximum. Select either separate statement for Network Benefits and Non-Network Benefits (and delete the combined choice) or select the combined option (and delete the separate Network/Non-Network choices). *[1]Include if OOPDM includes Copayments.[2]Include for plans with Copayment and Coinsurance options and the OOPDM does not include Copayments.* [The maximum amount you are required to pay for covered Prescription Drug Products in a single year. Once you reach the Out-of-Pocket Drug Maximum, you will not be required to pay [[1]Copayments or] Coinsurance for covered Prescription Drug Products for the remainder of the year. [[2]The Out-of-Pocket Drug Maximum does not include Copayments.]] *Include when there is a separate Specialty Prescription Drug Product OOPM.* [Copayments and Coinsurance for covered Specialty Prescription Drug Products are not limited by the Out-of-Pocket Drug Maximum.] *Include when Infertility is a Covered Health Service and Copayments and Coinsurance for Infertility drugs do not apply to the OOPDM. Standard is to include.* [Copayments and Coinsurance for covered Prescription Drug Products for Infertility are not limited by the Out-of-Pocket Drug Maximum.]	*Insert maximum amounts according to benefit design chosen by group.* *[1]Include if Copayments and Coinsurance are not subject to an Out-of-Pocket Drug Maximum.* *[2]Include if Copayments and/or Coinsurance are subject to an Out-of-Pocket Drug Maximum and the benefit design includes an Annual Drug Deductible.* *[3]If an Annual Drug Deductible applies, select the appropriate statement about whether or not the Annual Drug Deductible applies to the OOPDM.* [***Network]*** *Include when individual OOPDM applies* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) OOPDM applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] [[1]Copayments and Coinsurance for Prescription Drug Products are not limited by an Out-of-Pocket Drug Maximum.] [[2]The Out-of-Pocket Drug Maximum [[3]includes] [[3]does not include] the Annual Drug Deductible.] [***Non-Network]*** *Include when individual OOPDM applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) OOPDM applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] [[1]Copayments and Coinsurance for Prescription Drug Products are not limited by an Out-of-Pocket Drug Maximum.] [[2]The Out-of-Pocket Drug Maximum [[3]includes] [[3]does not include] the Annual Drug Deductible.] [***Network and Non-Network]*** *Include when individual OOPDM applies.* [$[XX – XX] per Covered Person.] *Include when individual (with family maximum) OOPDM applies.* [$[XX – XX] per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] [[2]The Out-of-Pocket Drug Maximum [[3]includes] [[3]does not include] the Annual Drug Deductible.]

Payment Term And Description	Amounts
Include when there is a separate SOOPDM. **[Specialty Prescription Drug Product Out-of-Pocket Maximum]**	
Include text if Copayments and/or Coinsurance are limited by the Specialty Prescription Drug Product Out-of-Pocket Maximum. [1]Include if SOOPM includes Copayments.[2]Include for plans with Copayment and Coinsurance options and the SOOPM does not include Copayments. [The maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single year. Once you reach the Specialty Prescription Drug Product Out-of-Pocket Maximum, you will not be required to pay [[1]Copayments or] Coinsurance for covered Specialty Prescription Drug Products for the remainder of the year. [[2]The Specialty Prescription Drug Product Out-of-Pocket Maximum does not include Copayments.]] *Include when Infertility is a Covered Health Service and Copayments and Coinsurance for Infertility drugs do not apply to the SOOPM. Standard is to include.* [Copayments and Coinsurance for covered Specialty Prescription Drug Products for Infertility are not limited by the Specialty Prescription Drug Product Out-of-Pocket Maximum.]	*Insert maximum amounts according to benefit design chosen by group.* *[1]Include when a separate Specialty Prescription Drug Product Out-of-Pocket Maximum applies to growth hormone therapy and/or per Therapeutic Class.* *[2]Include if Copayments and/or Coinsurance are subject to a Specialty Prescription Drug Product Out-of-Pocket Maximum and the benefit design includes a Specialty Prescription Drug Product Annual Deductible.* *[3]If a Specialty Prescription Drug Product Annual Deductible applies, select the appropriate statement about whether or not the Specialty Prescription Drug Product Annual Deductible applies to the Specialty Prescription Drug Product Out-of-Pocket Maximum.* *[4]Include if Copayments and Coinsurance are not subject to a Specialty Prescription Drug Product Out-of-Pocket Maximum.* *Include for groups that purchase Specialty pharmacy and an SOOPM applies separately to all Specialty Prescription Drug Products.* [***Specialty Prescription Drug Product]*** *Include when individual SOOPM applies.* [$[XX – XX] for Specialty Prescription Drug Products per Covered Person.] [[1]This does not include any maximum stated below.] *Include when individual (with family maximum) SOOPM applies.* [$[XX – XX] for Specialty Prescription Drug Products per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] [[1]This does not include any maximum stated below.] [[2]This Specialty Prescription Drug Product Out-of-Pocket Maximum [[3]includes] [[3]does not include] the Specialty Prescription Drug Product Annual Deductible.] [[4]Copayments and Coinsurance for covered Specialty Prescription Drug Products are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] *Include for groups that purchase Specialty pharmacy and SOOPM applies per Specialty Prescription Drug Product.* [***Specialty - Per Specialty Prescription Drug Product]*** *Include when individual SOOPM per product applies.* [$[XX – XX] per Specialty Prescription Drug Product per Covered Person.] [[1]This does not include any maximum stated below.] *Include when individual (with family maximum) SOOPM per product*

Payment Term And Description	Amounts
	applies.
	[$[XX – XX] per Specialty Prescription Drug Product per Covered Person, not to exceed $[XX – XX] per Specialty Prescription Drug Product for all Covered Persons in a family.] [[1]This does not include any maximum stated below.]
	[[2]This Specialty Prescription Drug Product Out-of-Pocket Maximum [[3]includes] [[3]does not include] the Specialty Prescription Drug Product Annual Deductible.]
	Include for groups that purchase Specialty pharmacy and a separate SOOPM applies for growth hormone therapy products.
	[***Specialty - Growth Hormone Therapy]***
	Include when individual SOOPM for Growth Hormone applies
	[$[XX – XX] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person.]
	Include when individual (with family maximum) SOOPM for Growth Hormone applies.
	[$[XX – XX] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person, not to exceed $[XX – XX] for growth hormone therapy for all Covered Persons in a family.]
	[[2]This Specialty Prescription Drug Product Out-of-Pocket Maximum [[3]includes] [[3]does not include] the Specialty Prescription Drug Product Annual Deductible.]
	Include the paragraphs below if the Specialty Out-of-Pocket Maximum applies per Therapeutic Class and include the applicable SOOPM amount or no SOOPM based on plan design.
	[***Specialty - per Therapeutic Class]***
	Include when individual SOOPM per Therapeutic Class A applies
	[$[XX – XX] for Specialty Prescription Drug Products in Therapeutic Class A per Covered Person.]
	Include when individual (with family maximum) SOOPM per Therapeutic Class A applies.
	[$[XX – XX] for Specialty Prescription Drug Products in Therapeutic Class A per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.]
	[[4]Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class A are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.]
	[[2]This Specialty Prescription Drug Product Out-of-Pocket Maximum [[3]includes] [[3]does not include] the Specialty Prescription Drug Product Annual Deductible.]
	Include when individual SOOPM per Therapeutic Class B applies.
	[$[XX – XX] for Specialty Prescription Drug Products in Therapeutic Class B per Covered Person.]

Payment Term And Description	Amounts
	Include when individual (with family maximum) SOOPM per Therapeutic Class B applies. [$[XX – XX] for Specialty Prescription Drug Products in Therapeutic Class B per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] [[4]Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class B are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] [[2]This Specialty Prescription Drug Product Out-of-Pocket Maximum [[3]includes] [[3]does not include] the Specialty Prescription Drug Product Annual Deductible.] *Include when individual SOOPM per Therapeutic Class C applies.* [$[XX – XX] for Specialty Prescription Drug Products in Therapeutic Class C per Covered Person.] *Include when individual (with family maximum) SOOPM per Therapeutic Class C applies.* [$[XX – XX] for Specialty Prescription Drug Products in Therapeutic Class C per Covered Person, not to exceed $[XX – XX] for all Covered Persons in a family.] [[4]Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class C are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.] [[2]This Specialty Prescription Drug Product Out-of-Pocket Maximum [[3]includes] [[3]does not include] the Specialty Prescription Drug Product Annual Deductible.]
[Annual Maximum Drug Benefit] *Include text if there is an Annual Maximum Drug Benefit.* [The maximum amount we will pay for covered Prescription Drug Products during the year.]	*Choose separate maximum for Network and Non-Network Benefits or a combined maximum, depending on plan design.* *Insert maximum amounts according to benefit design chosen by group.* [***Network]*** [$[XX - XX] per Covered Person.] *Insert maximum amounts according to benefit design chosen by group.* [***Non-Network]*** [$[XX - XX] per Covered Person.] *Insert maximum amounts according to benefit design chosen by group.* [***Network and Non-Network]*** [$[XX - XX] per Covered Person.]
[Specialty Prescription Drug Product Annual Maximum Benefit]	
Include text if there is a Specialty Prescription Drug Product Annual	*Include for groups that purchase the Specialty Drug program with an*

Payment Term And Description	Amounts
Maximum Benefit. [The maximum amount we will pay for covered Specialty Prescription Drug Products during a year.] *Include if there is an overall Annual Maximum Drug Benefit in this Rider.* [The Specialty Prescription Drug Product Annual Maximum Benefit is included in the overall Annual Maximum Drug Benefit stated above.]	*Annual Maximum for Specialty Prescription Drug Products.* *Insert maximum amounts according to benefit design chosen by group.* *[1]Include when a separate annual maximum applies for growth hormone therapy and/or per Therapeutic Class.* [***Specialty Prescription Drug Product]*** [$[XX - XX] for Specialty Prescription Drug Products per Covered Person.] [[1]This does not include any maximum stated below.] *Include for groups that purchase the specialty program with an Annual Maximum per Specialty Drug.* *Insert maximum amounts according to benefit design chosen by group.* *[1]Include when a separate annual maximum applies for growth hormone therapy and/or per Therapeutic Class.* [***Specialty - Per Specialty Prescription Drug Product]*** [$[XX - XX] per Specialty Prescription Drug Product per Covered Person.] [[1]This does not include any maximum stated below.] *Include for groups that purchase the specialty program with an Annual Maximum for Growth Hormone Therapy.* *Insert maximum amounts according to benefit design chosen by group.* [***Specialty - Growth Hormone Therapy]*** [$[XX - XX] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person.] *Include the paragraphs below if the Specialty Annual Maximum applies per Therapeutic Class and include the applicable number of classes.* [***Specialty - Per Therapeutic Class]*** [$[XX - XX] per Therapeutic Class A for Specialty Prescription Drug Products per Covered Person.] [$[XX - XX] per Therapeutic Class B for Specialty Prescription Drug Products per Covered Person.] [$[XX - XX] per Therapeutic Class C for Specialty Prescription Drug Products per Covered Person.]
[Infertility Annual Maximum Benefit]	
Include text if there is an Infertility Annual Maximum Benefit. [The maximum amount we will pay for covered Prescription Drug Products for Infertility during a year.] *Include if there is an overall Annual Maximum Drug Benefit in this Rider.* [The Infertility Annual Maximum Benefit is included in the overall Annual	*Insert maximum amounts according to benefit design chosen by group.* *Standard is $7,000 per Covered Person.* [$[XX - XX] per Covered Person.]

Payment Term And Description	Amounts
Maximum Drug Benefit stated above.]	
[Infertility Maximum Policy Benefit]	
Include text if there is an Infertility Maximum Policy Benefit and an Infertility Benefit is included in the Medical coverage. [The maximum amount we will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Policy.]	*Include when there is a Maximum Policy Benefit for Infertility drugs.* *Insert maximum amounts according to benefit design chosen by group. Standard is $7,000 per Covered Person.* [$[XX - XX] per Covered Person.]
[Specialty Prescription Drug Product Maximum Policy Benefit]	
Include text if there is a Specialty Prescription Drug Product Maximum Policy Benefit. [The maximum amount we will pay for covered Specialty Prescription Drug Products during the entire period of time you are enrolled for coverage under the Policy.]	*Include when there is a Maximum Policy Benefit for Specialty Prescription drugs.* *Insert maximum amounts according to benefit design chosen by group.* [$[XX - XX] per Covered Person.]
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network or non-Network Pharmacy is a specific dollar amount. ***Coinsurance*** Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Cost. Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate. ***Copayment and Coinsurance*** Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. *Include when programs are available for enhanced benefits*	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance or • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. *Include for groups that purchase the mail order pharmacy benefit.* [For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment and/or Coinsurance or • The Prescription Drug Cost for that Prescription Drug Product.] See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts.

Payment Term And Description	Amounts
[1]*Include when notification is required.* [2]*Include when prior authorization is required.* [Your Copayment and/or Coinsurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable [[1]notification] [[2]prior authorization], participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.] Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication regimens. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Include when plan includes Specialty Drug Program. **[Specialty Prescription Drug Products]**	
[The following supply limits apply. • As written by the provider, up to a consecutive [31] [60]-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive [31]-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. *[1]Include commas and "or" as required to accommodate plan design. [2] Include when plan design includes mail order pharmacy benefits. [3]Include when plan design includes Designated Pharmacy.* Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy [[1],] [[1]or] a non-Network Pharmacy [[1],] [[1]or] [[2]a mail order Network Pharmacy] [[1]or] [[3]a Designated Pharmacy].]	*Benefits are provided for either a 2-Tier, 3-Tier, 4-Tier, 5-Tier, or 6-Tier Benefit. [1]Delete comma and include "or" when benefit design is 2 Tier. Include comma and delete "or" when benefit design is 3 Tier or more. [2] Delete comma and include "or" when benefit design is 3 Tier. Include comma and delete "or" when benefit design is 4 Tier or more. [3] Delete comma and include "or" when benefit design is 4 Tier. Include comma and delete "or" when benefit design is 5 Tier or more. [4] Delete comma and include "or" when benefit design is 5 Tier. Include comma and delete "or" when benefit design is 6 Tier. [5]Include when benefit design is 6 Tier.* *[7]Always include introductory paragraph and Copayment and Coinsurance statements unless the Plan Design has a combined medical/RX Annual Deductible equal to the combined medical/RX OOPM, in which case delete the introductory paragraph and all tiered Copayment and Coinsurance options and choose [6]"No Copayment."* [[7]Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3] or] [Tier-4] [[4],] [[4] or] [Tier-5] [[5], or Tier-6]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] ***[Network Pharmacy]*** *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Specialty Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Prescription Drug Cost for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after

Description and Supply Limits	Benefit (The Amount We Pay)
	you pay a Copayment of $[___]]] [[8], and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A,B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Specialty Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Prescription Drug Cost for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[8], and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you

Description and Supply Limits	Benefit (The Amount We Pay)
	pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 3 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A,B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Specialty Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Prescription Drug Cost for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[8], and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below if the benefit design is 4 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for*

Description and Supply Limits	Benefit (The Amount We Pay)
	specific Therapeutic Classes (A,B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design. [For a Tier-4 Specialty Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Prescription Drug Cost for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[8], and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below if the benefit design is 5 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A,B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-5 Specialty Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Prescription Drug Cost for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a

Description and Supply Limits	Benefit (The Amount We Pay)
	Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[8], and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-5 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below only if the benefit design is 6 Tier. *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A,B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.*
	[For a Tier-6 Specialty Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Prescription Drug Cost for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[8], and] [[___]% of the Prescription Drug Cost for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount.

Description and Supply Limits	Benefit (The Amount We Pay)
	Choose appropriate combination per plan design. [For a Tier-6 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] [[6]No Copayment] ***[Non-Network Pharmacy]*** *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A,B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Specialty Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[8], and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per*

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	Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A,B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-2 Specialty Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[8], and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-2 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below only if the benefit design is 3 Tier or more. *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A,B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.*
	[For a Tier-3 Specialty Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of

Description and Supply Limits	Benefit (The Amount We Pay)
	$[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[8], and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below if the benefit design is 4 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A,B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-4 Specialty Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[8], and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you

Description and Supply Limits	Benefit (The Amount We Pay)
	will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-4 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below if the benefit design is 5 Tier or more.
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A,B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-5 Specialty Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[8], and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-5 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement

Description and Supply Limits	Benefit (The Amount We Pay)
	Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 6 Tier.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for growth hormone therapy and/ or per Therapeutic Class. [3]Include when there is a separate Copayment and/or Coinsurance for growth hormone therapy. [4]Include when growth hormone and therapeutic Copayments and/or Coinsurance are included. [5]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B, and/or C). [6]Include "," when A, B, and C apply. [7]Include "and" when only A&B apply. [8]Include when C applies. [9]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-6 Specialty Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][___] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [[1]after you pay a Copayment of $[___]]] [[4]and we pay] [[5][___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[6],] [[7]and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[8], and] [[___]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[9][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-6 Specialty Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] [[6]No Copayment] *Include when Closed Benefit Plan applies* *[1]Delete comma and include "or" when there is a closed benefit plan with 2 Tiers (Closed Benefit Plan). Include comma and delete "or" when closed benefit plan is 3 Tier or more. [2] Delete comma and include "or" when Closed benefit is 3 Tier. Include comma and delete "or" when*

Description and Supply Limits	Benefit (The Amount We Pay)
	closed benefit plan is 4 Tier or more. [3] Delete comma and include "or" when the closed benefit plan is 4 Tier. Include comma and delete "or" when closed benefit plan is 5 Tier. [4] Include when closed benefit design is 5 Tier. [Specialty Prescription Drug Products that are not on Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3]or] [Tier-4] [[4]or Tier-5] of the Prescription Drug List are not covered.]
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • If the Network Pharmacy agrees to provide the same services or products for the same terms as the Mail Order Network Pharmacy, you may obtain up to a consecutive 90-day supply of a Prescription Drug Product. *Contraceptives are mandated in AR, except for religious group employers. [1]Remove for religious employers who choose to exclude contraceptive coverage.* • [[1]A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied.] When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. *[1]Include when plan design includes Preferred Retail Network Pharmacy and Copayments and/or Coinsurance are reduced for Prescription Drug Products obtained at a Preferred pharmacy. Select Copayment and Coinsurance*	*Benefits are provided for either 2-Tier, 3-Tier, 4-Tier, 5-Tier, or 6-Tier Benefit. [1]Delete comma and include "or" when benefit design is 2 Tier. Include comma and delete "or" when benefit design is 3 Tier or more. [2] Delete comma and include "or" when benefit design is 3 Tier. Include comma and delete "or" when benefit design is 4 Tier or more. [3] Delete comma and include "or" when benefit design is 4 Tier. Include comma and delete "or" when benefit design is 5 Tier or more. [4] Delete comma and include "or" when benefit design is 5 Tier. Include comma and delete "or" when benefit design is 6 Tier. [5]Include when benefit design is 6 Tier.* *[7]Always include introductory paragraph and Copayment and Coinsurance statements unless the Plan Design has a combined medical/RX Annual Deductible equal to the combined medical/RX OOPM, in which case delete the introductory paragraph and all tiered Copayment and Coinsurance options and choose [6]"No Copayment".* [[7]Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3] or] [Tier-4] [[4],] [[4] or] [Tier-5] [[5], or Tier-6]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per

Description and Supply Limits	Benefit (The Amount We Pay)
options depending on plan design. *[2]Include when plan design includes Preferred Retail Network Pharmacy and Copayments and/or Coinsurance are increased when Prescription Drug Products are obtained at a non-Preferred pharmacy. Select Copayment and Coinsurance options depending on plan design.* [[1]If you use a Preferred Retail Network Pharmacy, your Copayment will be reduced by [$XX] per Prescription Order or Refill.] [[1]If you use a Preferred Retail Network Pharmacy, your Coinsurance will be reduced by [__]% of the Prescription Drug Cost per Prescription Order or Refill.] [[2]If you use a Non-Preferred Retail Network Pharmacy, your Copayment will be increased by [$XX] per Prescription Order or Refill.] [[2]If you use a Non-Preferred Retail Network Pharmacy, your Coinsurance will be increased by [__]% of the Prescription Drug Cost per Prescription Order or Refill.]	Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 3 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include*

Description and Supply Limits	Benefit (The Amount We Pay)
	when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-3 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-3 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below only if the benefit design is 4 Tier or more. *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.*
	[For a Tier-4 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment

Description and Supply Limits	Benefit (The Amount We Pay)
	is required. [2]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.*
	[For a Tier-4 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below only if the benefit design is 5 Tier or more.
	[1]*Include when a Copayment is required.* [2]*Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes.* [3]*Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C).* [4]*Include "," when A, B, and C apply.* [5]*Include "and" when only A&B apply.* [6]*Include when C applies.* [7]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.*
	[For a Tier-5 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]*Include when a Copayment is required.* [2]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.*
	[For a Tier-5 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below only if the benefit design is 6 Tier.
	[1]*Include when a Copayment is required.* [2]*Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes.* [3]*Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C).* [4]*Include "," when A, B, and C apply.* [5]*Include "and" when only A&B apply.* [6]*Include when C applies.* [7]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount.*

Description and Supply Limits	Benefit (The Amount We Pay)
	Choose appropriate combination per plan design. [For a Tier-6 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-6 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] [[6]No Copayment] *Include when plan design includes some level of closed benefit plan.* *[1]Delete comma and include "or" when there is a closed benefit plan with 2 Tiers (Closed Benefit Plan). Include comma and delete "or" when closed benefit plan is 3 Tier or more. [2] Delete comma and include "or" when Closed benefit is 3 Tier. Include comma and delete "or" when closed benefit plan is 4 Tier or more. [3] Delete comma and include "or" when the closed benefit plan is 4 Tier. Include comma and delete "or" when closed benefit plan is 5 Tier. [4] Include when closed benefit design is 5 Tier.* [Prescription Drug Products that are not on Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3]or] [Tier-4] [[4]or Tier-5] of the Prescription Drug List are not covered.]
Prescription Drugs from a Retail Non-Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. *Contraceptives are mandated in AR,*	*Benefits are provided for either a 2-Tier, 3-Tier, 4-Tier, 5-Tier, or 6-Tier Benefit. [1]Delete comma and include "or" when benefit design is 2 Tier. Include comma and delete "or" when benefit design is 3 Tier or more. [2] Delete comma and include "or" when benefit design is 3 Tier. Include comma and delete "or" when benefit design is 4 Tier or more. [3] Delete comma and include "or" when benefit design is 4 Tier. Include comma and delete "or" when benefit design is 5 Tier or more. [4] Delete comma and include "or" when benefit design is 5 Tier. Include comma and delete*

Description and Supply Limits	Benefit (The Amount We Pay)
except for religious group employers. [1]Remove for religious employers who choose to exclude contraceptive coverage. • [[1]A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied.] When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	*"or" when benefit design is 6 Tier. [5]Include when benefit design is 6 Tier.* *[7]Always include introductory paragraph and Copayment and Coinsurance statements unless the Plan Design has a combined medical/RX Annual Deductible equal to the combined medical/RX OOPM, in which case delete the introductory paragraph and all tiered Copayment and Coinsurance options and choose. [6]"No Copayment."* [[7]Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3] or] [Tier-4] [[4],] [[4] or] [Tier-5] [[5], or Tier-6]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include ","*

Description and Supply Limits	Benefit (The Amount We Pay)
	when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design. [For a Tier-2 Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 3 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per

Description and Supply Limits	Benefit (The Amount We Pay)
	Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-3 Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below only if the benefit design is 4 Tier or more.
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-4 Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-4 Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below only if the benefit design is 5 Tier or more.
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic

Description and Supply Limits	Benefit (The Amount We Pay)
	Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design. [For a Tier-5 Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-5 Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 6 Tier.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-6 Prescription Drug Product: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will

Description and Supply Limits	Benefit (The Amount We Pay)
	not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-6 Prescription Drug Product on the List of Preventive Medications: [___]% of the Predominant Reimbursement Rate [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] [[6]No Copayment] *Include when plan includes some level of closed benefit plan* *[1]Delete comma and include "or" when there is a closed benefit plan with 2 Tiers (Closed Benefit Plan). Include comma and delete "or" when closed benefit plan is 3 Tier or more. [2] Delete comma and include "or" when Closed benefit is 3 Tier. Include comma and delete "or" when closed benefit plan is 4 Tier or more. [3] Delete comma and include "or" when the closed benefit plan is 4 Tier. Include comma and delete "or" when closed benefit plan is 5 Tier. [4] Include when closed benefit design is 5 Tier.* [Prescription Drug Products that are not on Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3]or] [Tier-4] [[4] or Tier-5] of the Prescription Drug List are not covered.]
Include for groups that purchase the mail order benefit. **[Prescription Drug Products from a Mail Order Network Pharmacy]**	
[The following supply limits apply: *[1]Include if benefit plan design includes specialty drug program.* *[2]Include if benefit plan design includes the List of Preventive Medications.* • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. [[1]These supply limits do not apply to Specialty Prescription Drug Products[[2], including Specialty Prescription Drug Products on the List of Preventive Medications].	*Benefits are provided for either a 2-Tier, 3-Tier, 4-Tier, 5-Tier, or 6-Tier Benefit. [1]Delete comma and include "or" when benefit design is 2 Tier. Include comma and delete "or" when benefit design is 3 Tier or more. [2] Delete comma and include "or" when benefit design is 3 Tier. Include comma and delete "or" when benefit design is 4 Tier or more. [3] Delete comma and include "or" when benefit design is 4 Tier. Include comma and delete "or" when benefit design is 5 Tier or more. [4] Delete comma and include "or" when benefit design is 5 Tier. Include comma and delete "or" when benefit design is 6 Tier. [5]Include when benefit design is 6 Tier.* *[7]Always include introductory paragraph and Copayment and/or Coinsurance statements unless the Plan Design has a combined medical/RX Annual Deductible equal to the combined medical/RX OOPM, in which case delete the introductory paragraph and all tiered Copayment and Coinsurance options and choose [6]"No Copayment."* [[8]Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the

Description and Supply Limits	Benefit (The Amount We Pay)
Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products*.]	Prescription Drug List are assigned to Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3] or] [Tier-4] [[4],] [[4] or] [Tier-5] [[5], or Tier-6]. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine tier status.]
Include if coverage is initially required at a retail pharmacy prior to using mail order.	*There are two Copayment and/or Coinsurance options. The first is to tie the number of days' supply to the Copayment and/or Coinsurance level at 31 days, 60 days and 90 days. The second option is to apply a Copayment and/or Coinsurance, calculated only at the 90-day level, for any number of days' supply of mail order drugs.*
[You may be required to fill an initial Prescription Drug Product order and obtain [1 - 3] refill[s] through a retail pharmacy prior to using a mail order Network Pharmacy.]	*Include text when Copayments and/or Coinsurance are tied to a number-of-days' supply. Delete if a single Copayment and/or Coinsurance applies to any supply of mail order drugs.* [For up to a 31-day supply, we pay:]
Include the following paragraph only when mail order Copayments and/or Coinsurance in the right hand column are charged for the full 90 day supply. Delete if Copayments and/or Coinsurance are tied to the 31, 60 and 90 day supply.	*[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.*
[To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.]]	[For a Tier-1 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-1 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include*

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	when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-2 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-2 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below only if the benefit design is 3 Tier or more. *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.*
	[For a Tier-3 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment

Description and Supply Limits	Benefit (The Amount We Pay)
	is required. [2]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.*
	[For a Tier-3 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below only if the benefit design is 4 Tier or more.
	[1]*Include when a Copayment is required.* [2]*Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes.* [3]*Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C).* [4]*Include "," when A, B, and C apply.* [5]*Include "and" when only A&B apply.* [6]*Include when C applies.* [7]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.*
	[For a Tier-4 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]*Include when a Copayment is required.* [2]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.*
	[For a Tier-4 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below only if the benefit design is 5 Tier or more.
	[1]*Include when a Copayment is required.* [2]*Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes.* [3]*Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C).* [4]*Include "," when A, B, and C apply.* [5]*Include "and" when only A&B apply.* [6]*Include when C applies.* [7]*Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount.*

Description and Supply Limits	Benefit (The Amount We Pay)
	Choose appropriate combination per plan design. [For a Tier-5 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-5 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 6 Tier.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-6 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount.*

Description and Supply Limits	Benefit (The Amount We Pay)
	Choose appropriate combination per plan design.
	[For a Tier-6 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include following paragraphs (describing a 60-day supply limit) only when Copayments and/or Coinsurance are tied to days' supply. Delete if a single Copayment and/or Coinsurance applies to any supply of mail order drugs.
	[For up to a 60-day supply, we pay:]
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-1 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-1 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is

Description and Supply Limits	Benefit (The Amount We Pay)
	limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design. [For a Tier-2 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 3 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited*

Description and Supply Limits	Benefit (The Amount We Pay)
	by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-3 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below only if the benefit design is 4 Tier or more.
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-4 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-4 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below only if the benefit design is 5 Tier or more.
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount.

Description and Supply Limits	Benefit (The Amount We Pay)
	Choose appropriate combination per plan design. [For a Tier-5 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-5 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 6 Tier.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-6 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount.*

Description and Supply Limits	Benefit (The Amount We Pay)
	Choose appropriate combination per plan design.
	[For a Tier-6 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include following paragraphs describing a 90-day supply limit only when Copayments and/or Coinsurance are tied to days' supply. Delete if a single Copayment and/or Coinsurance applies to any supply of mail order drugs.
	[For up to a 90-day supply, we pay:]
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-1 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-1 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is

Description and Supply Limits	Benefit (The Amount We Pay)
	limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design. [For a Tier-2 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-2 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below if the benefit design is 3 Tier or more.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-3 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited*

Description and Supply Limits	Benefit (The Amount We Pay)
	by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-3 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below if the benefit design is 4 Tier or more.
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-4 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.
	[For a Tier-4 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]]
	Include the paragraph below if the benefit design is 5 Tier or more.
	[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount.

Description and Supply Limits	Benefit (The Amount We Pay)
	Choose appropriate combination per plan design. [For a Tier-5 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-5 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include the paragraph below only if the benefit design is 6 Tier.* *[1]Include when a Copayment is required. [2]Include when there is separate Copayment and/or Coinsurance for Therapeutic Class or per Therapeutic Classes. [3]Include when there is separate Copayment and/or Coinsurance for specific Therapeutic Classes (A, B and/or C). [4]Include "," when A, B, and C apply. [5]Include "and" when only A&B apply. [6]Include when C applies. [7]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount. Choose appropriate combination per plan design.* [For a Tier-6 Prescription Drug Product: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill [[2], except that we pay [[3][__]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [[1]after you pay a Copayment of $[___]]] [[4],] [[5]and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [[1]after you pay a Copayment of $[___]]] [[6], and] [[___]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [[1]after you pay a Copayment of $[___]]] per Prescription Order or Refill]. [[7][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] *Include when there is a separate Copayment and/or Coinsurance for drugs on the List of Preventive Medications. [1]Include when a Copayment is required. [2]Include for Coinsurance plans when amount paid is limited by a dollar amount more than and/or less than a specific amount.*

Description and Supply Limits	Benefit (The Amount We Pay)
	Choose appropriate combination per plan design. [For a Tier-6 Prescription Drug Product on the List of Preventive Medications: [___]% of the Prescription Drug Cost [[1]after you pay a Copayment of $[___]] per Prescription Order or Refill. [[2][However,] [you will not pay less than [$___]] [you will not pay more than [$___]] [you will not pay less than [$___] and you will not pay more than [$___]] per Prescription Order or Refill.]] [[6]No Copayment] *Include when plan includes some level of closed benefit plan* *[1]Delete comma and include "or" when there is a closed benefit plan with 2 Tiers (Closed Benefit Plan). Include comma and delete "or" when closed benefit plan is 3 Tier or more. [2] Delete comma and include "or" when Closed benefit is 3 Tier. Include comma and delete "or" when closed benefit plan is 4 Tier or more. [3] Delete comma and include "or" when the closed benefit plan is 4 Tier. Include comma and delete "or" when closed benefit plan is 5 Tier. [4] Include when closed benefit design is 5 Tier.* [Prescription Drug Products that are not on Tier-1 [[1],] [[1]or] [Tier-2] [[2],] [[2]or] [Tier-3] [[3],] [[3]or] [Tier-4] [[4] or Tier-5] of the Prescription Drug List are not covered.]

IRS Medical Care Rider

UnitedHealthcare Insurance Company

This Rider is part of the Policy issued by [UnitedHealthcare Insurance Company to the Enrolling Group.

We provide Benefits for Covered Health Services that meet the definition of an allowable tax deductible item of "medical care" as defined by *Section 213(d)* of the *Internal Revenue Code of 1986* and as may be amended from time to time.

"Medical care" means services and supplies for the diagnosis, cure, mitigation, treatment or prevention of disease, and for treatments affecting any part or function of the body. The Covered Health Service must be given primarily to alleviate or prevent a physical or mental defect or illness. Expenses for solely cosmetic reasons generally are not expenses for medical care. Also, expenses that are merely beneficial to one's general health are not expenses for medical care.

See the *Internal Revenue Service* guidelines for limitations and other conditions.

This Rider will not affect any of the terms, provisions, or conditions of the Policy except as stated above.

_____

Name, Title

UnitedHealthcare [Options PPO]

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

[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.

You can choose to receive [[1]Designated 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.]

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

[2]Include and delete #1if 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.]

[2]Include 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. [[2]Covered 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.]

[1]Always 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 [[1]through 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 [[1]when 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. [[1]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.

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

When you choose to receive certain Covered Health Services from [[1]Network 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 [[1]over $[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 [[1]over $[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.]

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

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

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

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

[1]Include 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. [1]Include when Manipulative Treatment is included in the rehabilitation services benefit.

- [Rehabilitation services [[1]and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [[1]Manipulative 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, [[1]Mental Illness,] [[2]mental 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, [[1]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. [1]Include when MH benefits are sold. [2]Include when SUD benefits are sold. [3]Include when both MH and SUD benefits are sold. [1-A]Include when benefits for Neurobiological Disorders - Autism Spectrum Disorders are sold.

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

[[[1]Mental Health Services [[1-A](including psychiatric services for Autism Spectrum Disorders)]] [[3]and] [[2]Substance 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 [[1]Mental Health Services] [[3]or] [[2]Substance 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 Coordination℠

When we are notified as required, we will work with you to implement the Care Coordination℠ 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 [[1]Designated 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]Include when the Annual Deductible applies only to Non-Network Benefits. *[2]Include when an Outpatient Prescription Drug Rider is sold and the Annual Deductible applies to any combination of medical and RX benefits.* *[3]Include when an Outpatient Prescription Drug Rider with separate Copayments for preventive medications is sold and the Annual Deductible does not apply to preventive medications.* *[4]Include when an Outpatient Prescription Drug Rider is sold and when the Annual Deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the Annual Deductible.* *[5]Include 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.* *[6]Include 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 [[1]Non-Network] Benefits. [[2]The 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*. [[3]Benefits for Outpatient Prescription Drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [[4]Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the Outpatient Prescription Drug Rider are not subject to payment of the Annual Deductible.] [[5]The Annual Deductible for [[6]Designated 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.]	*[1]Include 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.* *[2]Include 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-*

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.

[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. [1]Include 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. [[1]This 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.]

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]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).* [$[0 - 15,000] per Covered Person.] *Include when individual (with family maximum) deductible applies (embedded).* [$[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.]
Include only when a per occurrence deductible applies. **[Per Occurrence Deductible]**	
[The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.]	*[1]Include when Designated Network Benefits apply to either category.* ***[[[1]Designated Network and] Network]*** *Include when a per occurrence deductible applies to CHD surgery benefits.* [CHD surgery - Inpatient Stay: [$100 - 1,000] per day.] [CHD surgery - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to inpatient hospital benefits.* [Hospital - Inpatient Stay: [$100 - 1,000] per day.] [Hospital - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to outpatient surgery benefits.* [Surgery - Outpatient: [$10 - 1,000] per date of service.] *Include when a per occurrence deductible applies to inpatient transplant benefits.* [Transplant - Inpatient Stay: [$100 - 1,000] per day.] [Transplant - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] ***[Non-Network]*** *Include when a per occurrence deductible applies to CHD surgery*

	benefits. [CHD surgery - Inpatient Stay: [$100 - 1,000] per day.] [CHD surgery - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to inpatient hospital benefits.* [Hospital - Inpatient Stay: [$100 - 1,000] per day.] [Hospital - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to outpatient surgery benefits.* [Surgery - Outpatient: [$50 - 800] per date of service.] *Include when a per occurrence deductible applies to inpatient transplant benefits.* [Transplant - Inpatient Stay: [$100 - 1,000] per day.] [Transplant - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.]
Out-of-Pocket Maximum	

[1]Include when OOPM includes the Annual Deductible.

[2]Include when OOPM includes the Per Occurrence Deductible.

[3]Include when OOPM includes Copayments.

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

[5]Include 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.

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

The maximum you pay per year for [[1]the Annual Deductible,] [[2]the Per Occurrence Deductible,] [[3]Copayments] [[1-2-3]or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [[4]The 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*.] [[5]The Out-of-Pocket Maximum for [[6]Designated 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*.]

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

[[7]Copayments 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

[1]Include 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.

[2]Include 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

sold and Copayments/Coinsurance do not apply to the overall OOPM. • [Copayments or Coinsurance for Covered Health Services provided under the *Outpatient Prescription Drug Rider*.]	include the Per Occurrence Deductible.] *Include when there is no OOPM.* [No Out-of-Pocket Maximum.] ***[[1]Non-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 include the Per Occurrence Deductible.] *Include when there is no OOPM.* [No Out-of-Pocket Maximum.] *[3]Include combined Network and Non-Network heading and statements below*

	when OOPM provision applies 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.* ***[[3][2]Designated Network,] Network and Non-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 include the Per Occurrence Deductible.]

	Include when there is no OOPM. [No Out-of-Pocket Maximum.]
Maximum Policy Benefit	
The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Policy.	*[1]Include when separate Network and Non-Network Maximums apply.* *[2]Include when Designated Network Benefits apply to any category.* ***[[1][2]Designated Network and] Network]*** [$[1,000,000 - 10,000,000] per Covered Person.] [No Maximum Policy Benefit.] ***[[1]Non-Network]*** [$[1,000,000 - 10,000,000] per Covered Person.] [No Maximum Policy Benefit.] *[3]Include when combined Network and Non-Network Maximums applies.* ***[[3][2]Designated Network,] Network and Non-Network]*** [$[1,000,000 - 10,000,000] per Covered Person.]
Include only when an annual maximum benefit applies. **[Annual Maximum Benefit]**	

[The maximum amount we will pay for Benefits during the year.]	*[1]Include when separate Network and Non-Network Maximums apply.* *[2]Include when Designated Network Benefits apply to any category.* ***[[1][2]Designated Network and] Network]*** [$[2,000 - 500,000] per Covered Person.] ***[[1]Non-Network]*** [$[2,000 - 500,000] per Covered Person.] *[3]Include when combined Network and Non-Network Maximums applies.* ***[[3][2]Designated Network,] Network and Non-Network]*** [$[2,000 - 500,000] per Covered Person.]
Copayment	
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. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Benefit Limits

Include when benefit plan design has no additional limits.

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

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

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

Include when orthopedic surgery is limited.

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

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

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

- [Benefits for Covered Health Services for orthopedic surgery for joint replacement are limited to [[1]a 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] [[3]a 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 [[1]a 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] [[3]a 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?**
Include for groups that purchase benefits for acupuncture services. **1. [Acupuncture Services]**			
Include the limit selected by the group. [Limited to [10 - 100] visits per year.] [Limited to [10 - 100] visits per year, not to exceed $[100 - 5,000] in Eligible Expenses per year.] [Limited to $[100 - $5,000] in Eligible Expenses per year.] [This limit applies to Network Benefits only. Non-Network Benefits are not available.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available.]
[2.] Ambulance Services			
Pre-service Notification Requirement 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.			
Emergency Ambulance	***Network***		

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?**
Include the limit selected by the group. [Ground ambulance limited to $[500 - 5,000] per year.]	*Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 - 1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]	[Yes] [No]	[Yes] [No]
Include the limit selected by the group. [Air ambulance limited to $[1,000 - 10,000] per year.]	*Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] [100% after you pay a Copayment of $[2,500 - 10,000] per day] [100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]]	[Yes] [No]	[Yes] [No]
	Non-Network Same as Network	Same as Network	Same as Network
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	***Network*** *Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 -	[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?**
	1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]] *Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] [100% after you pay a Copayment of $[2,500 - 10,000] per day] [100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]] ***Non-Network*** Same as Network	[Yes] [No] Same as Network	[Yes] [No] Same as Network
Include for groups that purchase benefits for clinical trials. **[3.] [Clinical Trials]**			
When Clinical Trials benefit is included, pre-service notification requirement will always apply. **[Pre-service Notification Requirement]** [You must notify us as soon as the possibility of participation in a clinical trial arises. If you don't notify us, you will be responsible for paying all charges and no Benefits will be paid.]			
[Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*. Benefits are available when the Covered Health Services are provided by either Network or non-Network	***[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 *Schedule of Benefits*.] ***[Non-Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each		

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?**
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.)]	Covered Health Service category in this *Schedule of Benefits*.]		
Include for groups that purchase benefits for congenital heart disease services. **[4.] [Congenital Heart Disease Surgeries]**			
Include if pre-service notification is required. *[1]Include if Non-Network Benefits are sold and if use of a Designated Facility is required in order to receive Network Benefits.* **[Pre-service Notification Requirement]** [For Designated Network Benefits you must notify us as soon as the possibility of a Congenital Heart Disease (CHD) surgery arises. If you do not notify us and if, as a result, the CHD services are not performed at a Designated Network Facility, Designated Network Benefits will not be paid.] [[1]Non-Network Benefits will apply.]] *Include when notification is required.* *[1]Include when the Covered Person is responsible for notification for Network Benefits.* *[2]Include applicable reduction in Benefits.* [For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses].			
Include when Designated Network Benefits are available. [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.] *Include when CHD benefits are sold and when both Network and Non-*	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

When 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?**
Network Benefits are available. [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 *Schedule of Benefits*.]	Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]		
Include when use of a Designated Facility is required in order to receive Network Benefits. [For Network Benefits, CHD surgeries must be received at a Designated Facility. 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. 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 *Schedule of Benefits*.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
Include when Network and Non-Network Benefits are limited and insert the limit selected by the group. [Network and Non-Network Benefits are limited to $[30,000 - 250,000] per CHD surgery.] *Include when Non-Network Benefits are limited and insert the limit selected*	***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

When 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?**
by the group. [Non-Network Benefits are limited to $[30,000 - 250,000] per CHD surgery.]	Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]		
Include for groups that purchase benefits for accident-related dental services. **[5.] [Dental Services - Accident Only]**			
Include when pre-service notification is required. *[1]Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [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, [[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.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] ***[Non-Network]*** [Same as Network]	[Yes] [No] [Same as Network]	[Yes] [No] [Same as Network]
[6.] Diabetes Services			
[1]Include when the Covered Person is responsible for notification for Network Benefits. *[2]Include when the durable medical equipment benefit is sold.* *[3]Include when the durable medical equipment benefit is not sold.* *[4]Include when notification applies only to equipment that exceeds a minimum dollar amount and insert applicable dollar amount.* *[5]Include applicable reduction in Benefits or no Benefits.*			

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?**
Pre-service Notification Requirement For [[1]Network and] Non-Network Benefits you must notify us before obtaining any [[2]Durable Medical Equipment] [[3]diabetes equipment] for the management and treatment of diabetes [[4]that 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, [[5]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[5]you will be responsible for paying all charges and no Benefits will be paid].			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	***Network*** 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 *Schedule of Benefits*. ***Non-Network*** 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 *Schedule of Benefits*.		
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment*. *Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.* [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].]	***Network*** *[[1]Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.* [[1]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*.] *[[2]Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold.* *[[3]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[[4]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[2]For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [[3]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[4]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[[5]Include when benefits for durable medical equipment are not*		

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?**
	sold and the Outpatient Prescription Drug Rider is sold. *[6]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[7]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[5]For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [[6]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[7]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[8]Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold.* *[9]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[10]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[8]For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [[9]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[10]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] ***Non-Network*** *[1]Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.* [[1]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*.] *[2]Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold.* *[3]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[4]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[2]For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% 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 [[3]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[4]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[5]Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold.* *[6]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[7]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[5]For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [[6]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[7]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[8]Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold.* *[9]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[10]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[8]For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [[9]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[10]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
Include for groups that purchase benefits for DME. **[7.] [Durable Medical Equipment]**			

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

[2]Include when notification applies only to DME that exceeds a minimum dollar amount and insert applicable dollar amount.

[3]Include applicable reduction in Benefits or no Benefits.

[Pre-service Notification Requirement]

[For [[1]Network and] Non-Network Benefits you must notify us before obtaining any Durable Medical Equipment [[2]that 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, [[3]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[3]you will be responsible for paying all charges and no Benefits will be paid].]

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?**
Include the limit selected by the group. *[1]Include either option as standard plan design.* [[1]Limited to $[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].] [[1]Limited per year as follows: • [$[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.] 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].] *[1]Include when Benefits are provided for speech aid and tracheo-esophageal voice devices.* *[2]Include when devices are not included in the annual DME limit.* [[1]Benefits 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 [[2]not] included in the annual limits stated above.]	***[Network]*** [[50 - 100]%]	[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?**
	[Non-Network] [[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?**
Include when benefit is limited. [Limited to $[100 - 5,000] per year.] **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. *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.)* [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: • [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.] • [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and*	***Network*** [[50 - 100]%] *Include bracketed provision and select either #1 or #2 if the Copayment is waived.* *[1]Include as standard; [2]Include only to match prior benefit plans.* [100% after you pay a Copayment of $[5 - 500] per visit. [If you are admitted as an inpatient to a Network Hospital [[1]directly from the Emergency room] [[2]within 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.]] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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] *Include for 2-tiered Copayment option.*	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
Nuclear Medicine - Outpatient.] • [Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.] • [Outpatient surgery procedures described under *Surgery - Outpatient*.] • [Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.] *[1]Include bracketed reference to Manipulative treatment when Manipulative treatment benefits are sold.* • [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [*[1]and *Manipulative Treatment]*.]]	[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] *Include for 3-tiered Copayment option.* [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] *Include for 4-tiered Copayment option.* [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]		

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?**
	Include if plan design includes retrospective review of emergency services. [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] ***Non-Network*** Same as Network	Same as Network	Same as Network
[9.] Hearing Aids *Include as standard for groups of 2 to 15 and 15+.*			
Include the limit selected by the group. *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.* [Limited to $[2800 - 5,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[three-five] years].] No Copayment, Coinsurance or Deductible will be applicable to Network or non-Network Hearing Aid Coverage.	***[Network]*** [[50 - 100]%] ***[Non-Network]***	[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?**
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[10.] Home Health Care			
Include if pre-service notification is required. *[1]Include when the Covered Person is responsible for notification for Network Benefits.* *[2]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For [[1]Network and] Non-Network Benefits 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 [[2]50 - 95]% of Eligible Expenses.]			
Include the limit selected by the group. [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.] [Network Benefits are limited to [40 - 200] visits per year and Non-Network Benefits are limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.] *Include when infusion administration only is not included in the limit.* [This visit limit does not include any service which is billed only for the administration of intravenous infusion.]	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit]	[Yes] [No]	[Yes] [No]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit]	[Yes] [No]	[Yes] [No]
[11.] Hospice Care			
Include if pre-service notification is required.			

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?
[1]Include when the Covered Person is responsible for notification for Network Benefits. *[2]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For [1]Network and] 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 [2]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [In addition, for [1]Network and] Non-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]			
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per day] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per day]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[12.] Hospital - Inpatient Stay			
Include when Benefit Activation Program is sold. *[1]Include applicable Benefit level.* **[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 [1]50 - 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 *Customer Care* at the telephone number on your ID card.] *[1]Include when the Covered Person is responsible for notification for Network Benefits.* *[2]Include applicable Benefit level.* **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			

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?**
Eligible Expenses.			
Include if pre-admission notification is required.			
[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).]			
[1]Include heading and row when Designated Network Benefits apply. *Include when enhanced benefits apply to specific inpatient services.* *[2]Include when Physician's fees are paid under the facility charge.* [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:] • [The Copayment you pay for the facility charge [[2]and 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 [[2]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].] [You can determine the specific surgical procedures or diagnoses 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.]	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

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?**
	Network		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		[Yes, after the Per Occurrence Deductible is satisfied]
	[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 - 10,000] per Inpatient Stay]		
	Non-Network		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[100 - 1,000] per day]		[Yes, after the Per Occurrence Deductible is satisfied]
	[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 - 10,000] per Inpatient Stay]		

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?**
Include for groups that purchase infertility benefits. **[13]. [Infertility Services]**			
When this benefit is purchased, pre-service notification will always be required. [1]Include applicable reduction in Benefits or no Benefits. **[Pre-service Notification Requirement]** [You must notify us as soon as the possibility of the need for Infertility Services arises. If you fail to notify us as required, [[1]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[1]you will be responsible for paying all charges and no Benefits will be paid].]			
[1]Include heading and row when Designated Network Benefits apply.	***[[1]Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
Include the limit selected by the group. *[1]Include when the maximum benefit is combined with infertility drugs under the RX rider.* [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. [[1]This limit includes Benefits for infertility medications provided under the *Outpatient Prescription Drug Rider*.] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.]	***[Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Non-Network] [[50 - 100]%] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]
[14.] Lab, X-Ray and Diagnostics - Outpatient			
Include when pre-service notification is required for sleep studies.			

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?**
[1]Include when the Covered Person is responsible for notification for Network Benefits. *[2]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For [1]Network 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 [2]50 - 95]% of Eligible Expenses.]			
[1]Include heading and row when Designated Network Benefits apply. *Include limit selected by group.* [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 $[5 - 100] per service]	[Yes] [No]	[Yes] [No]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service]	[Yes] [No]	[Yes] [No]
	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			
Include when pre-service notification is required for CT, PET, MRI, MRA and nuclear medicine. *[1]Include when the Covered Person is responsible for notification for Network Benefits.* *[2]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For [1]Network 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 [2]50 - 95]% of Eligible Expenses.]			
[1]Include heading and row when Designated Network Benefits apply.	***[[1]Designated Network]***		

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?**
Include limit selected by group. [Limited to $[100 - 5,000] per year.] [Non-Network Benefits are limited to $[100 - 5,000] per year.]	[[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]
Include for groups that purchase mental health benefits. *[Include as standard for groups of 2 to 15]* *[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.* *[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 exempt from Parity requirements.*	***[Network]*** *[Inpatient/Intermediate]* [[50 - 100]%] [100% after you pay a	[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?**
Include the limit selected by the group. *When parity does not apply, this first set of separate benefit statements and limits can be used. When parity does apply, delete these benefit and limit statements and use the "Depending upon" provisions further below."*	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]		
Select from these limit options when limits apply only to Mental Health Services described in this section. [Inpatient/Intermediate *Mental Health Services* are limited to [10 - 100] days per year.] [Outpatient *Mental Health Services* are limited to [10 - 100] visits per year.] [Non-Network Benefits for Inpatient/Intermediate *Mental Health Services* are limited to [10 - 100] days per year.] [Non-Network Benefits for outpatient *Mental Health Services* are limited to [10 - 100] visits per year.] *Select from these limit options when limits apply to Mental Health Services described in this section combined with Neurobiological Disorders - Autism Spectrum Disorders below.* [Benefits for any combination of *Mental Health Services* described in this section and *Neurobiological Disorders - Autism Spectrum Disorders* described below are limited as follows: • [10 - 100] days per year for Inpatient/Intermediate *Mental*	*[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] ***[Non-Network]*** *[Inpatient/Intermediate]* [[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	[Yes] [No] [Yes] [No]	[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?**
Health Services and *Neurobiological Disorders - Autism Spectrum Disorders*. • [10 - 100] visits per year for outpatient *Mental Health Services* and *Neurobiological Disorders - Autism Spectrum Disorders*.]	Inpatient Stay]		
Select from these limit options when limits apply to Mental Health Services described in this section combined with Substance Use Disorder Services below. [Benefits for any combination of *Mental Health Services* described in this section and *Substance Use Disorder Services* described below are limited as follows: • [10 - 100] days per year for Inpatient/Intermediate *Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Mental Health Services* and *Substance Use Disorder Services*.]	*[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]	[Yes] [No]	[Yes] [No]
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.*	***[Network]*** [Depending upon where the Covered Health Service is provided, Benefits for outpatient *Mental Health Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate *Mental Health Services* will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
	[Non-Network] [Depending upon where the Covered Health Service is provided, Benefits for outpatient *Mental Health Services* will be		

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?**
	the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate *Mental Health Services* will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
Include for groups that purchase mental health benefits. **[17.] [Neurobiological Disorders - Autism Spectrum Disorder Services]**			
When this benefit is purchased, prior authorization will always be required. [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 exempt from Parity requirements. Include the limit selected by the group.* *When parity does not apply, this first set of separate benefit statements and limits can be used. When parity does apply, delete these benefit and limit statements and use the "Depending upon" provisions further below."*	***[Network]*** *[Inpatient/Intermediate]* [[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	[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?**
	Inpatient Stay]		
Select from these limit options when limits apply only to Neurobiological Disorders - Autism Spectrum Disorders described in this section. [Inpatient/Intermediate *Neurobiological Disorders -Autism Spectrum Disorders* are limited to [10 - 100] days per year.] [Outpatient *Neurobiological Disorders - Autism Spectrum Disorders* are limited to [10 - 100] visits per year.] [Non-Network Benefits for Inpatient/Intermediate *Neurobiological Disorders -Autism Spectrum Disorders* are limited to [10 - 100] days per year.] [Non-Network Benefits for outpatient *Neurobiological Disorders -Autism Spectrum Disorders* are limited to [10 - 100] visits per year.] *Select from these limit options when limits apply to Neurobiological Disorders - Autism Spectrum Disorders described in this section combined with Mental Health Services above.* [Benefits for any combination of *Neurobiological Disorders - Autism Spectrum Disorders* described in this section and *Mental Health Services* described above are limited as follows: • [10 - 100] days per year for Inpatient/Intermediate *Neurobiological Disorders - Autism Spectrum Disorders* and *Mental Health Services*. • [10 - 100] visits per year for outpatient *Neurobiological Disorders - Autism Spectrum Disorders* and *Mental Health Services*.]	*[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] ***[Non-Network]*** *[Inpatient/Intermediate]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No] [Yes] [No]	[Yes] [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?**
	[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]	[Yes] [No]	[Yes] [No]
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.*	***[Network]*** [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*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
	[Non-Network] [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*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		

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?
Include for groups that purchase benefits for obesity surgery. **[18.] [Obesity Surgery]**			

When this benefit is purchased, pre-service notification will always be required. [1]Include applicable Benefit level.

[Pre-service Notification Requirement]

[You must notify us [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]

Include if pre-admission notification is required.

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

[In addition, for [[1]Network and] Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.]

[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]

[1]Include heading and row when Designated Network Benefits apply.

[2]Include when Designated Network Benefits apply.

[3]Include when Network Benefits are available.

[4]Insert the limit selected by the group.

[Any combination of [[2]Designated Network Benefits] [[3], Network Benefits] and Non-Network Benefits is limited to $[[4]50,000 - 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 $[[4]5,000 - 30,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]

[[1]Designated Network]

[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]

[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 *Schedule of Benefits*.]

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?**
Include when there is not a Network level of benefits available. [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.]	***[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 *Schedule of Benefits*.]		
Include if group purchases benefits for ostomy supplies. **[19.] [Ostomy Supplies]**			
Include the limit selected by the group. [Limited to $[500 - 25,000] per year.]	***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[20.] Pharmaceutical Products - Outpatient			
Include when notification is required for IV infusions. *[1]Include when the Covered Person is responsible for notification for Network Benefits.* *[2]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses.] *Include when notification is required for select Pharmaceutical Products.* [For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses. 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.]			
[1]Include heading and row when Designated Network Benefits apply. *Include limit selected by group.*	***[[1]Designated Network]*** [[50 - 100]%]	[Yes] [No] [Yes, except	[Yes] [No] [Yes, except when

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?**
[Limited to $[100 - 5,000] per year.] [Non-Network Benefits are limited to $[100 - 5,000] per year.]	[100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] *Include when Coinsurance is tiered and select the appropriate number of tiers by plan design.* [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] ***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] *Include when Coinsurance is tiered and select the appropriate number of tiers by plan design.* [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] ***Non-Network***	when provided during a Physician office visit] [Yes] [No] [Yes, except when provided during a Physician office visit]	provided during a Physician office visit] [Yes] [No] [Yes, except when provided during a Physician office visit]

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]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] *Include when Coinsurance is tiered and select the appropriate number of tiers by plan design.* [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]	[Yes] [No] [Yes, except when provided during a Physician office visit]	[Yes] [No] [Yes, except when provided during a Physician office visit]
[21.] Physician Fees for Surgical and Medical Services			
Include when Benefit Activation Program is sold. *[1]Include applicable Benefit level.* **[Benefit Activation Notification Requirement]** [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 [[1]50 - 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 *Customer Care* at the telephone number on your ID card.]			
[1]Include heading and row when Designated Network Benefits apply. *Include when enhanced benefits apply to specific Physician services.* [When you choose to seek care [as a result of certain diagnoses or] from Designated Network Physicians as	***[[1]Designated Network]*** [[50 - 100]%]	[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?**
identified below, your Benefits will be enhanced as described:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] **[Enhanced Benefits:]** • [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].] [You can determine the specific services for which enhanced Benefits are available by going to [www.myuhc.com] or by calling			

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?**
Customer Care at the telephone number on your ID card.] [2]*Include text if the plan design supports paying non-network benefits for a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist).* [[2]Covered 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.] [3]*Include text if the plan design supports paying non-network benefits for a non-Network consulting Physician, assistant surgeon or surgical assistant.* [[3]Covered 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.]	***Network*** [50 - 100]% ***Non-Network*** [50 - 100]%	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[22.] Physician's Office Services - Sickness and Injury			

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?**
Include when Benefit Activation Program is sold. *[1]Include applicable Benefit level.* **[Benefit Activation Notification Requirement]** [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 [[1]50 - 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 *Customer Care* at the telephone number on your ID card.]			
Include if group chooses to limit benefit. [1]Insert limit selected by group. [Limited to [[1]2 - 10] visits per year.] *[1]Include heading and row when Designated Network Benefits apply.* *Include when enhanced benefits apply to specific physician office services.* [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:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.]	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [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] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
• [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] **[Enhanced Benefits:]** • [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].] [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.]	that year] [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] [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]		
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	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
subject to Coinsurance only.) [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: • [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.] • [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*.] • [Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.] • [Outpatient surgery procedures described under *Surgery - Outpatient*.] • [Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.] *[1]Include bracketed reference to Manipulative treatment when Manipulative treatment benefits are sold.* • [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment].*]]	per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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] [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] ***Non-Network***		

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]%] [100% after you pay a Copayment of $[5 - 100] per visit] [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] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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] [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	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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]		
[1]Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude. [2]If Maternity Services are excluded, Complications of Pregnancy must always be included. **[23.] Pregnancy - [[1]Maternity Services] [[2]Complications of Pregnancy only]**			

[1]Include when benefits are provided for maternity services.

[2]Include when the Covered Person is responsible for notification for Network Benefits.

[3]Include applicable Benefit level.

[[1]Pre-service Notification Requirement]

[[1]For [[2]Network 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 [[3]50 - 95]% of Eligible Expenses.]

[4]Include when benefits are provided for complications of pregnancy only.

[5]Include when the Covered Person is responsible for notification for Network Benefits.

[6]Include applicable Benefit level.

[[4]Pre-service Notification Requirement]

[[4]For [[5]Network 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 [[6]50 - 95]% of Eligible Expenses.]

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.

[1]Include when benefits are provided for maternity services.

[[1]Network]

[3]Include when an annual deductible applies to network benefits.

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?**
	[4Include when Network services in the Physician's office are subject to a Copayment. [[1]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* [[3]except 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]. [[4]For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.] ***[[1]Non-Network]*** *[3Include when an annual deductible applies to non-network benefits.* *[4Include when Non-Network services in the Physician's office are subject to a Copayment.* [[1]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* [[3]except 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]. [[4]For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.] *[2Include when benefits are provided for complications of pregnancy only.* ***[[2]Network]*** [[2]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[[2]Non-Network]*** [[2]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
[24.] Preventive Care Services			
Include when preventive care is limited and select the limit that applies. [Preventive care services are limited to $[100 - 1,000] per year.] **Physician office services** • Well baby and well child care includes, but is limited to, 20	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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 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. No Copayment, Coinsurance or deductible will be applicable to Network or non-Network children's immunizations.	per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available except for children under the age of 19.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available except for children under the age of 19.]

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: No deductible will be applicable to Network or non-Network Prostate Cancer Screening.	[Non-Network Benefits are not available.] ***Network*** [[50 - 100]%] [100% after you pay a 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 except for children under the age of 19.]	[Yes] [No] [Yes] [No] [Non-Network Benefits are not available except for children under the age of 19.]	[Yes] [No] [Yes] [No] [Non-Network Benefits are not available except for children under the age of 19.]
[25.] Prosthetic Devices and Services			
Include if notification is required. *[1]Include when the Covered Person is responsible for notification for Network Benefits.* *[2]Include when notification applies only to prosthetics that exceed a minimum dollar amount and insert applicable dollar amount.* *[3]Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [For [[1]Network and] Non-Network Benefits you must notify us before obtaining prosthetic devices [[2]that exceed $[1,000 - 5,000] in cost per device]. If you fail to notify us as required, [[3]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[3]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			

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?

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

[2]Include applicable Benefit level.

Pre-service Notification Requirement

For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses.

Include if pre-admission notification is required.

[In addition, for [[1]Network 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).]

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 *Schedule of Benefits*.

Include when group does not purchase benefits for prosthetic devices.

[1]Include when sold with a plan that has an annual deductible and select either "are" or "are not."

[2]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."

[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [[1]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[2]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]

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 *Schedule of Benefits*.

Include when group does not purchase benefits for prosthetic devices. The Benefit level inserted here must be the same as the plan Coinsurance level.

[1]Include when sold with a plan that has an annual deductible and select either "are" or "are not."

[2]Include when sold with a plan that has an out-of-pocket

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 and select either "applies" or "does not apply." [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [[1]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[2]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
Include entire section when rehabilitation services benefit is sold. *[1]Include when Manipulative Treatment benefits are sold.* **[27.] [Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment]]**			
Include when notification is required for any rehabilitation service. *[1]Include when the Covered Person is responsible for notification for Network Benefits.* *[2]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses.]			
Include when per therapy limits apply. *[1]Include when Manipulative Treatment benefits are sold.* *[2]Include when vision therapy benefits are sold.* [Limited per year as follows: • [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.	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
• [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.]] *Include when combined therapy visit limits apply.* *[1]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.* *[2]Include when vision therapy benefits are sold.* [Any combination of physical therapy, occupational therapy, [[1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [[2]and vision therapy] is limited to [10 - 160] visits per year.] *Include when combined therapy dollar limits apply.* *[1]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.* *[2]Include when vision therapy benefits are sold.* [Any combination of physical therapy, occupational therapy, [[1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy,	***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?
cardiac rehabilitation therapy, post-cochlear implant aural therapy, [[2]and vision therapy] is limited to $[750 - 12,000] per year.] *Include when combined therapy visit limits apply separately to network benefits and to non-network benefits.* *[1]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.* *[2]Include when vision therapy benefits are sold.* [Network Benefits for any combination of physical therapy, occupational therapy, [[1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [[2]and vision therapy] are limited to [10 - 160] visits per year.] [Non-Network Benefits for any combination of physical therapy, occupational therapy, [[1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [[2]and vision therapy] are limited to [10 - 160] visits per year.]			
[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			

Include when notification is required for scopic procedures.

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

[2]Include applicable Benefit level.

[Pre-service Notification 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?**
[For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses.]			
[1]Include heading and row when Designated Network Benefits apply.	***[[1]Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	Network [50 - 100]%	[Yes] [No]	[Yes] [No]
	Non-Network [50 - 100]%	[Yes] [No]	[Yes] [No]
[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
[1]Include when the Covered Person is responsible for notification for Network Benefits. *[2]Include applicable Benefit level.*			
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. If you fail to notify us as required, Benefits will be reduced to [[2]50 - 95]% of Eligible Expenses.			
Include if pre-admission notification is required.			
[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).]			
Include limit selected by group. [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.]	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] *Copayment option below identified as #1 to be tied only to either of the options #1 below with an Inpatient Stay maximum.* [[1]100% after you pay a	[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?**
	Copayment of $[50 - 2,000] per Inpatient Stay] [[1]100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 5,000] per Inpatient Stay] *Variable #1 can be used only with options numbered #1 above.* [[1]If 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.] [No Copayment applies if you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility.] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day]	[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?**
	[100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay]		
Include for groups that purchase substance use disorder benefits.[Include as standard for groups of 2 to 15] **[30.] Substance Use Disorder Services**			
When this benefit is purchased, prior authorization will always be required. *[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 exempt from Parity requirements. Include the limit selected by the group.* *When parity does not apply, this first set of separate benefit statements and limits can be used. When parity does apply, delete these benefit and limit statements and use the "Depending upon" provisions further below."*	***[Network]*** *[Inpatient/Intermediate]* [[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	[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?**
	maximum Copayment of $[100 - 5,000] per Inpatient Stay]		
Select from these limit options when limits apply only to Substance Use Disorder Services described in this section. [Inpatient/Intermediate *Substance Use Disorder Services* are limited to [10 - 100] days per year.] [Outpatient *Substance Use Disorder Services* are limited to [10 - 100] visits per year.] [Non-Network Benefits for Inpatient/Intermediate *Substance Use Disorder Services* are limited to [10 - 100] days per year.] [Non-Network Benefits for outpatient *Substance Use Disorder Services* are limited to [10 - 100] visits per year.] *Select from these limit options when limits apply to Substance Use Disorder Services described in this section combined with Mental Health Services above.* [Benefits for any combination of *Substance Use Disorder Services* described in this section and *Mental Health Services* described above are limited as follows: • [10 - 100] days per year for Inpatient/Intermediate *Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Mental Health Services* and *Substance Use Disorder Services*.]	*[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] ***[Non-Network]***	[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?**
	[Inpatient/Intermediate] [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No]
	[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]	[Yes] [No]	[Yes] [No]
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.*	***[Network]*** [Depending upon where the Covered Health Service is provided, Benefits for outpatient *Substance Use Disorder Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate *Substance Use Disorder Services* will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be		

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?**
	paid at 100%.]		
	[Non-Network] [Depending upon where the Covered Health Service is provided, Benefits for outpatient *Substance Use Disorder Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate *Substance Use Disorder* Services will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
[31.] Surgery - Outpatient			
Include when Benefit Activation Program is sold. *[1]Include applicable Benefit level.* **[Benefit Activation Notification Requirement]** [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 [[1]50 - 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 *Customer Care* at the telephone number on your ID card.] *Include when notification is required.* *[1]Include when the Covered Person is responsible for notification for Network Benefits.* *[2]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses.]			
[1]Include heading and row when Designated Network Benefits apply. *Include provision below when enhanced benefits apply to specific*	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence

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?**
outpatient surgical services. *[2]Include when Physician's fees are paid under the facility charge.* [When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as follows:] • [The Copayment you pay for the facility charge [[2]and 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 [[2]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].] [You can determine the specific surgical procedures 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.]	Copayment of $[10 - 1,000] per date of service] [100%after you pay a Copayment of $[10 - 1,000] per date of service, to a maximum Copayment of $[10 - 5,000] per year]]		Deductible is satisfied]
	Network [[50 - 100]%] [[100% after you pay a Copayment of $[10 - 1,000] per date of service] [100% after you pay a Copayment of $[10 - 1,000] per date of service, to a maximum	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

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 $[10 - 5,000] per year]] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[10 - 1,000] per date of service] [100% after you pay a Copayment of $[10 - 1,000] per date of service, to a maximum Copayment of $[10 - 5,000] per year]]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
Include when group purchases TMJ benefit. **[32.] [Temporomandibular Joint Services]**			
When this benefit is purchased, pre-service notification will always be required. *[1]Include when the Covered Person is responsible for notification for Network Benefits.* *[2]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [In addition, for [[1]Network and] Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions.]			
Include the limit selected by the group. [Limited to $[1,000 - 20,000] per year.]	***[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 *Schedule of Benefits*.] ***[Non-Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each		

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?**
	Covered Health Service category in this *Schedule of Benefits*.]		
[33.] Therapeutic Treatments - Outpatient			
Include when notification is required. *[1]Include when the Covered Person is responsible for notification for Network Benefits.* *[2]Include applicable Benefit level.*			
[Pre-service Notification Requirement] [For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses.]			
[1]Include heading and row when Designated Network Benefits apply.	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[25 - 100] per treatment]	[Yes] [No]	[Yes] [No]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[25 - 100] per treatment]	[Yes] [No]	[Yes] [No]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[25 - 100] per treatment]	[Yes] [No]	[Yes] [No]
[34.] Transplantation Services			
Pre-service Notification Requirement 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 result, the services are not performed at a Designated Facility, Network Benefits will not be paid. Non-			

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?**
Network Benefits will apply. *[2]Include applicable benefit reduction penalty.* For Non-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 fail to notify us as required, Benefits will be reduced to [[2]50 - 95]% of Eligible Expenses. *Include if pre-admission notification is required.* *[1]Include when the Covered Person is responsible for notification for Network Benefits.* [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).]			
For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits. *Include when Non-Network Benefits are limited and insert the limit selected by the group.* [Non-Network Benefits are limited to $[30,000 - 250,000] per transplant.]	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

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?**
	of $[100 - 5,000] per Inpatient Stay]		
[35.] Urgent Care Center Services			
Include when urgent care services are limited and insert the limit selected by the group. [Limited to $[100 - 5,000] per year.] [Limited to [2 - 10] visits per year.] *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.)* [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: • [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.] • [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*.] • [Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.] • [Outpatient surgery procedures described under *Surgery -*	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
Outpatient.] • [Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.] *[1]Include bracketed reference to Manipulative treatment when Manipulative treatment benefits are sold.* • [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [*[1]and *Manipulative Treatment]*.]]	***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]
Include when group purchases benefits for vision exams.			

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?**
[36.] [Vision Examinations]			
[Limited to [1 exam] [[2-3] exams] per year.] [Limited to [1 exam] [[2-3] exams] every [2 - 3] years.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of [$5 - 75] per visit] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of [$5 - 75] per visit] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]
Include when group purchases benefits for wigs. **[37.] [Wigs]**			
Include the limit selected by the group. [Limited to $[100 - 1,000] per year.] [Limited to $[100 - 5,000] every [24 - 36] months.]	***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
Additional Benefits Required By Arkansas Law			
[38.] Dental Services - Anesthesia and Hospitalization			
Pre-service Notification Requirement Any applicable notification requirements will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.			
[1]Include heading and row when Designated Network Benefits apply	[[1]***Designated Network***] [Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] ***Network***		

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 *Hospital - Inpatient Stay* in this *Schedule of Benefits*. ***Non-Network*** Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.		
[39.] In Vitro Fertilization Services			
[1]Include applicable Benefit level. **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.			
[1]Include heading and row when Designated Network Benefits apply Limited to a lifetime maximum of $15,000.	***[[1]Designated Network]*** [50 - 100%] ***Network*** [50 - 100%] ***Non-Network*** [[50 - 100]%] [Non-Network Benefits are not available.]	*[1]Include heading and row when Designated Network Benefits apply* Limited to a lifetime maximum of $15,000.	***[[1]Designated Network]*** [50 - 100%] ***Network*** [50 - 100%] ***Non-Network*** [[50 - 100]%] [Non-Network Benefits are not available.]
[40.] Medical Foods			
	[1]Include when group purchases the Outpatient Prescription Drug Rider. ***Network*** Depending upon where the Covered Health Service is provided, Benefits will be [50 - 100]% [[1]or as provided under the *Outpatient Prescription*	[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?**
	Drug Rider]. ***Non-Network*** Same as Network	Same as Network	Same as Network
Mandated offer in Arkansas. **[[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 *Schedule of Benefits*.]	***[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 *Schedule of Benefits*.]		
[Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*.]	***[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 *Schedule of Benefits*.]		
[42.] Orthotic Devices and Services			
Include if notification is required. *[1]1Include 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 [[1]Designated 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, [[1]Mental Illness,] [[2]mental 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 [[1]Designated Network Benefits and] Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a [[1]Designated 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.

  - **[**[1]For 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.

- **[**[2]Fee(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.

[1]Include when Exhibit 2 for more than one class of Eligible Persons is being amended.

[2]Choose the applicable class number.

Notice of Change to Exhibit 2 [[1]Class [[2]1-10]]

Effective [_____], the following provision(s) included in Exhibit 2 of this Policy are replaced by the provision(s) shown below.

[1]Enter new or revised class description.

1. **[Class Description.**

   [[1]All full-time employees.]]

Insert new or revised Eligibility conditions in A and B below. [1]Include when more than one class of Eligible Persons is covered.

[2.] [**Eligibility.** The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins of the Certificate of Coverage* [[1]applicable to this class]:

A. The waiting or probationary period for newly Eligible Persons is as follows:

[_____]

B. Other:

[_____]]

Insert new or revised Open Enrollment Period.

[1]Include this text if Open Enrollment Period applies to this class.

[2]Enter the applicable number of days in the Open Enrollment Period.

[3]Select the appropriate frequency of the open enrollment for this class.

[4]Include this text if Open Enrollment Period does not apply to this class.

[3.] [**Open Enrollment Period.** [[1]An Open Enrollment Period of at least [[2]30 - 60] days, will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on [[3]an annual basis] [[3]a quarterly basis] [[3]_____].][[4]No Open Enrollment Period applies to this class.]]

Insert new or revised Effective Date for Eligible Persons.

[1]Select the appropriate Effective Date.

[2]Use this for a free-form description of the Effective Date.

[4]. [**Effective Date for Eligible Persons.** For an Eligible Person who becomes eligible after the effective date of the Policy, his or her effective date of coverage is: [[1]the day following the last day of the required waiting period.] [[1]the first day of the month following the last day of the required waiting period.] [[1]the date the Eligible Person joins the Enrolling Group.] [[1]the first day of the month following the date the Eligible Person joins the Enrolling Group.][[2]as determined by the Enrolling Group, _____.]]

Insert new or revised Premium rates.

[1]Insert effective date of rate change.

[5]. [**Schedule of Premium Rates.** The schedule of Premium rates payable by or on behalf of this class of Covered Persons as of [[1]_____] is shown below:

[**Coverage Classification** **Monthly Premium**

Subscriber Only	$XXX.XX
Subscriber and Spouse	$XXX.XX
Subscriber plus one Child	$XXX.XX
Subscriber plus Family	$XXX.XX]]

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	07/06/2009
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	07/06/2009
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	07/06/2009
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	07/06/2009
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved-Closed	07/06/2009
Comments:			
Cover Letter			
Attachment:			
Cover letter.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Forms List	Approved-Closed	07/06/2009

Comments:

Forms List

Attachment:

2009 Forms List for filing Ins new.pdf

UnitedHealthcare®
A UnitedHealth Group Company

July 1, 2009

Rosalyn Minor

Arkansas Insurance Department

1200 West 3rd Street

Little Rock, Arkansas 72201

Re: UnitedHealthcare Insurance Company

NAIC No. 79413

Group Health Forms POL.H.09.AR et al.

Dear Madam/Sir:

On behalf of UnitedHealthcare Insurance Company, I am submitting the enclosed group health forms for your Department's review and approval. These documents are based on our 2007 Series documents filed and approved in your state. Revised forms are being filed to incorporate new Federal legislation and other business/product modifications. Our intent is to use these forms for large and small employer groups only. Similar forms are part of a nationwide filing. Because the enclosed forms have been modified to reflect the laws and regulations of Arkansas, they will not be filed with Connecticut, our State of Domicile. Once approved, these forms will be used in conjunction with all forms filed and approved for use with our 2007 Series forms.

Forms for Which We Seek Approval

The forms for which we seek approval are identified on the attached "Forms Listing." The readability/Flesch score is provided as well.

These materials represent final printed format (with the exception of variable text and corresponding instructions—please see the following paragraphs for explanation). Once approved, these forms will be used to support the issuance of our portfolio of group health products offered in your state. For a description of our products, please see the enclosed product description.

Explanation of Insert Forms and Variable Text

The forms contained in this filing are to be used on an insert form basis. In lieu of filing modifications via amendments, the insert form(s) impacted by the modification will be submitted for review and approval. Please refer to the "Forms Listing" for all of the forms to be used in conjunction with this new policy/certificate series.

Each insert form is made up of:

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

Include when group purchases benefits for obesity surgery.

Include when notification is required for hospice care.

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

If you have any questions or concerns regarding this submission, please feel free to call me at the number shown below

Sincerely,

Ebony N. Terry

Compliance Analyst

Enclosure

ENT

Ph: 301.838.5611
Fax: 301.838.5676

[Toll free: 800-250-6180 Ext. [85611]]
Email:

Forms Listing

For UnitedHealthcare Insurance Company

Form Number	Description of 2009 Forms	Flesch or Readability Score
	Employer Policy	
POL.I.09.AR	Group Policy	48.8
EXB2NTC.I.09.AR	Notice of Change to Exhibit 2	48.8
	Member Certificate of Coverage	
COC.CER.I.09.AR	Certificate of Coverage	70.7
COC.INT.I.09.AR	Introduction to Your Certificate	61.0
COC.YRP.I.09.AR	Your Responsibilities	56.2
COC.ORP.I.09.AR	Our Responsibilities	50.7
COC.TOC.I.09.AR	Table of Contents	69.3
COC.CHS.I.09.AR	Section 1: Covered Health Services	45.4
COC.EXC.I.09.AR	Section 2: Exclusions and Limitations	43.1
COC.BGN.I.09.AR	Section 3: When Coverage Begins	65.3
COC.END.I.09.AR	Section 4: When Coverage Ends	52.2
COC.CLM.I.09.AR	Section 5: How to File a Claim	64.9
COC.CPL.I.09.AR	Section 6: Questions, Complaints and Appeals	41.1
COC.COB.I.09.AR	Section 7: Coordination of Benefits	46.3
COC.LGL.I.09.AR	Section 8: General Legal Provisions	48.5
COC.DEF.I.09.AR	Section 9: Defined Terms	48.2
CCOV.I.09.AR	[insert insurance company name] [delete row if your state doesn't require information on the cover]	68.6

Form Number	Description of 2009 Forms	Flesch or Readability Score
	Schedules of Benefits	
SBN.CHP.I.09.AR	Schedule of Benefits for Choice Plus	49.8
SBN.NDF.I.09.AR	Schedule of Benefits for Non-Differential PPO	50.2
SBN.OPT.I.09.AR	Schedule of Benefits for Options PPO	49.8
	Optional Riders	
CATL.I.09.AR	[Catalyst] [Catalyst Choice] Rider	51.8
RDR.RXSBN.PLS.I.09.AR	Outpatient Prescription Drug Rider Schedule of Benefits(Net/Non-Net)	52.1
RDR.GENRX.PLS.I.09.AR	Outpatient Prescription Drug Rider- Generic RX (Net/Non-Net)	56.2
RDR.GENRXSBN.PLS.I.09.AR	Outpatient Prescription Drug Rider- Generic RX Schedule of Benefits(Net/Non-Net)	54.1
RDR.SHARERX.PLS.I.09.AR	Outpatient Prescription Drug Rider- Share RX (Net/Non-Net)	56.5
RDR.SHARERXSBN.PLS.I.09.AR	Outpatient Prescription Drug Rider- Share RX Schedule of Benefits(Net/Non-Net)	52.1
IRS.I.09.AR	IRS Medical Care Rider	60.3

Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/01/2009	Form	Schedule of Benefis Options PPO	09/27/2009	X09I_SBN_OPT.pdf (Superceded)
07/01/2009	Form	Schedule of Benefits	09/27/2009	X09I_SBN_NONDIFF.pdf (Superceded)
07/01/2009	Form	Schedule of Benefits Choice Plus	09/27/2009	X09I_SBN_CHCPLS.pdf (Superceded)
07/01/2009	Form	Certificate of Coverage	08/14/2009	X09I_COC.pdf
08/14/2009	Form	Certificate of Coverage	09/27/2009	X09I_COC.pdf (Superceded) X09I_COC final 8.7.09.pdf (Superceded)

UnitedHealthcare [Options PPO]

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

[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.

You can choose to receive [[1]Designated 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.]

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

[2]Include and delete #1if 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.]

[2]Include 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. [[2]Covered 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.]

[1]Always 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 [[1]through 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 [[1]when 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. [[1]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.

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

When you choose to receive certain Covered Health Services from [[1]Network 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 [[1]over $[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 [[1]over $[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.]

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

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

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

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

[1]Include 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. [1]Include when Manipulative Treatment is included in the rehabilitation services benefit.

- [Rehabilitation services [[1]and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [[1]Manipulative 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, [[1]Mental Illness,] [[2]mental 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, [[1]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. [1]Include when MH benefits are sold. [2]Include when SUD benefits are sold. [3]Include when both MH and SUD benefits are sold. [1-A]Include when benefits for Neurobiological Disorders - Autism Spectrum Disorders are sold.

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

[[[1]Mental Health Services [[1-A](including psychiatric services for Autism Spectrum Disorders)]] [[3]and] [[2]Substance 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 [[1]Mental Health Services] [[3]or] [[2]Substance 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 Coordination℠

When we are notified as required, we will work with you to implement the Care Coordination℠ 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 [[1]Designated 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]Include when the Annual Deductible applies only to Non-Network Benefits. *[2]Include when an Outpatient Prescription Drug Rider is sold and the Annual Deductible applies to any combination of medical and RX benefits.* *[3]Include when an Outpatient Prescription Drug Rider with separate Copayments for preventive medications is sold and the Annual Deductible does not apply to preventive medications.* *[4]Include when an Outpatient Prescription Drug Rider is sold and when the Annual Deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the Annual Deductible.* *[5]Include 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.* *[6]Include 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 [[1]Non-Network] Benefits. [[2]The 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*. [[3]Benefits for Outpatient Prescription Drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [[4]Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the Outpatient Prescription Drug Rider are not subject to payment of the Annual Deductible.] [[5]The Annual Deductible for [[6]Designated 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.]	*[1]Include 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.* *[2]Include 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-*

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.

[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. [1]Include 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. [[1]This 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.]

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]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).* [$[0 - 15,000] per Covered Person.] *Include when individual (with family maximum) deductible applies (embedded).* [$[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.]
Include only when a per occurrence deductible applies. **[Per Occurrence Deductible]**	
[The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.]	*[1]Include when Designated Network Benefits apply to either category.* ***[[[1]Designated Network and] Network]*** *Include when a per occurrence deductible applies to CHD surgery benefits.* [CHD surgery - Inpatient Stay: [$100 - 1,000] per day.] [CHD surgery - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to inpatient hospital benefits.* [Hospital - Inpatient Stay: [$100 - 1,000] per day.] [Hospital - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to outpatient surgery benefits.* [Surgery - Outpatient: [$10 - 1,000] per date of service.] *Include when a per occurrence deductible applies to inpatient transplant benefits.* [Transplant - Inpatient Stay: [$100 - 1,000] per day.] [Transplant - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] ***[Non-Network]*** *Include when a per occurrence deductible applies to CHD surgery*

	benefits. [CHD surgery - Inpatient Stay: [$100 - 1,000] per day.] [CHD surgery - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to inpatient hospital benefits.* [Hospital - Inpatient Stay: [$100 - 1,000] per day.] [Hospital - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to outpatient surgery benefits.* [Surgery - Outpatient: [$50 - 800] per date of service.] *Include when a per occurrence deductible applies to inpatient transplant benefits.* [Transplant - Inpatient Stay: [$100 - 1,000] per day.] [Transplant - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.]
Out-of-Pocket Maximum	

[1]Include when OOPM includes the Annual Deductible.

[2]Include when OOPM includes the Per Occurrence Deductible.

[3]Include when OOPM includes Copayments.

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

[5]Include 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.

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

The maximum you pay per year for [[1]the Annual Deductible,] [[2]the Per Occurrence Deductible,] [[3]Copayments] [[1-2-3]or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [[4]The 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*.] [[5]The Out-of-Pocket Maximum for [[6]Designated 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*.]

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

[[7]Copayments 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

[1]Include 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.

[2]Include 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

sold and Copayments/Coinsurance do not apply to the overall OOPM. • [Copayments or Coinsurance for Covered Health Services provided under the *Outpatient Prescription Drug Rider*.]	include the Per Occurrence Deductible.] *Include when there is no OOPM.* [No Out-of-Pocket Maximum.] ***[[1]Non-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 include the Per Occurrence Deductible.] *Include when there is no OOPM.* [No Out-of-Pocket Maximum.] *[3]Include combined Network and Non-Network heading and statements below*

	when OOPM provision applies 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.* ***[[3][2]Designated Network,] Network and Non-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 include the Per Occurrence Deductible.]

	Include when there is no OOPM. [No Out-of-Pocket Maximum.]
Maximum Policy Benefit	
The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Policy.	*[1]Include when separate Network and Non-Network Maximums apply.* *[2]Include when Designated Network Benefits apply to any category.* ***[[1][2]Designated Network and] Network]*** [$[1,000,000 - 10,000,000] per Covered Person.] [No Maximum Policy Benefit.] ***[[1]Non-Network]*** [$[1,000,000 - 10,000,000] per Covered Person.] [No Maximum Policy Benefit.] *[3]Include when combined Network and Non-Network Maximums applies.* ***[[3][2]Designated Network,] Network and Non-Network]*** [$[1,000,000 - 10,000,000] per Covered Person.]
Include only when an annual maximum benefit applies. **[Annual Maximum Benefit]**	

[The maximum amount we will pay for Benefits during the year.]	*[1]Include when separate Network and Non-Network Maximums apply.* *[2]Include when Designated Network Benefits apply to any category.* ***[[1][2]Designated Network and] Network]*** [$[2,000 - 500,000] per Covered Person.] ***[[1]Non-Network]*** [$[2,000 - 500,000] per Covered Person.] *[3]Include when combined Network and Non-Network Maximums applies.* ***[[3][2]Designated Network,] Network and Non-Network]*** [$[2,000 - 500,000] per Covered Person.]
Copayment	
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. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Benefit Limits

Include when benefit plan design has no additional limits.

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

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

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

Include when orthopedic surgery is limited.

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

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

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

- [Benefits for Covered Health Services for orthopedic surgery for joint replacement are limited to [[1]a 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] [[3]a 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 [[1]a 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] [[3]a 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?**
Include for groups that purchase benefits for acupuncture services. **1. [Acupuncture Services]**			
Include the limit selected by the group. [Limited to [10 - 100] visits per year.] [Limited to [10 - 100] visits per year, not to exceed $[100 - 5,000] in Eligible Expenses per year.] [Limited to $[100 - $5,000] in Eligible Expenses per year.] [This limit applies to Network Benefits only. Non-Network Benefits are not available.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available.]
[2.] Ambulance Services			
Pre-service Notification Requirement 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.			
Emergency Ambulance	***Network***		

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?**
Include the limit selected by the group. [Ground ambulance limited to $[500 - 5,000] per year.]	*Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 - 1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]	[Yes] [No]	[Yes] [No]
Include the limit selected by the group. [Air ambulance limited to $[1,000 - 10,000] per year.]	*Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] [100% after you pay a Copayment of $[2,500 - 10,000] per day] [100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]]	[Yes] [No]	[Yes] [No]
	Non-Network Same as Network	Same as Network	Same as Network
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	***Network*** *Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 -	[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?**
	1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]] *Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] [100% after you pay a Copayment of $[2,500 - 10,000] per day] [100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]] ***Non-Network*** Same as Network	[Yes] [No] Same as Network	[Yes] [No] Same as Network
Include for groups that purchase benefits for clinical trials. **[3.] [Clinical Trials]**			
When Clinical Trials benefit is included, pre-service notification requirement will always apply. **[Pre-service Notification Requirement]** [You must notify us as soon as the possibility of participation in a clinical trial arises. If you don't notify us, you will be responsible for paying all charges and no Benefits will be paid.]			
[Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*. Benefits are available when the Covered Health Services are provided by either Network or non-Network	***[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 *Schedule of Benefits*.] ***[Non-Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each		

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?**
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.)]	Covered Health Service category in this *Schedule of Benefits*.]		
Include for groups that purchase benefits for congenital heart disease services. **[4.] [Congenital Heart Disease Surgeries]**			
Include if pre-service notification is required. *[1]Include if Non-Network Benefits are sold and if use of a Designated Facility is required in order to receive Network Benefits.* **[Pre-service Notification Requirement]** [For Designated Network Benefits you must notify us as soon as the possibility of a Congenital Heart Disease (CHD) surgery arises. If you do not notify us and if, as a result, the CHD services are not performed at a Designated Network Facility, Designated Network Benefits will not be paid.] [[1]Non-Network Benefits will apply.]] *Include when notification is required.* *[1]Include when the Covered Person is responsible for notification for Network Benefits.* *[2]Include applicable reduction in Benefits.* [For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses].			
Include when Designated Network Benefits are available. [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.] *Include when CHD benefits are sold and when both Network and Non-*	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

When 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?**
Network Benefits are available. [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 *Schedule of Benefits*.]	Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]		
Include when use of a Designated Facility is required in order to receive Network Benefits. [For Network Benefits, CHD surgeries must be received at a Designated Facility. 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. 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 *Schedule of Benefits*.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
Include when Network and Non-Network Benefits are limited and insert the limit selected by the group. [Network and Non-Network Benefits are limited to $[30,000 - 250,000] per CHD surgery.] *Include when Non-Network Benefits are limited and insert the limit selected*	***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

When 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?**
by the group. [Non-Network Benefits are limited to $[30,000 - 250,000] per CHD surgery.]	Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]		
Include for groups that purchase benefits for accident-related dental services. **[5.] [Dental Services - Accident Only]**			
Include when pre-service notification is required. *[1]Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [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, [[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.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] ***[Non-Network]*** [Same as Network]	[Yes] [No] [Same as Network]	[Yes] [No] [Same as Network]
[6.] Diabetes Services			
[1]Include when the Covered Person is responsible for notification for Network Benefits. *[2]Include when the durable medical equipment benefit is sold.* *[3]Include when the durable medical equipment benefit is not sold.* *[4]Include when notification applies only to equipment that exceeds a minimum dollar amount and insert applicable dollar amount.* *[5]Include applicable reduction in Benefits or no Benefits.*			

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?**
Pre-service Notification Requirement For [[1]Network and] Non-Network Benefits you must notify us before obtaining any [[2]Durable Medical Equipment] [[3]diabetes equipment] for the management and treatment of diabetes [[4]that 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, [[5]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[5]you will be responsible for paying all charges and no Benefits will be paid].			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	***Network*** 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 *Schedule of Benefits*. ***Non-Network*** 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 *Schedule of Benefits*.		
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment*. *Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.* [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].]	***Network*** *[[1]Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.* [[1]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*.] *[[2]Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold.* *[[3]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[[4]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[2]For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [[3]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[4]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[[5]Include when benefits for durable medical equipment are not*		

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?**
	sold and the Outpatient Prescription Drug Rider is sold. *[6]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[7]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[5]For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [[6]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[7]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[8]Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold.* *[9]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[10]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[8]For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [[9]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[10]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] ***Non-Network*** *[1]Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.* [[1]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*.] *[2]Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold.* *[3]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[4]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[2]For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% 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 [[3]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[4]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[5]Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold.* *[6]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[7]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[5]For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [[6]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[7]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[8]Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold.* *[9]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[10]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[8]For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [[9]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[10]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
Include for groups that purchase benefits for DME. **[7.] [Durable Medical Equipment]**			

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

[2]Include when notification applies only to DME that exceeds a minimum dollar amount and insert applicable dollar amount.

[3]Include applicable reduction in Benefits or no Benefits.

[Pre-service Notification Requirement]

[For [[1]Network and] Non-Network Benefits you must notify us before obtaining any Durable Medical Equipment [[2]that 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, [[3]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[3]you will be responsible for paying all charges and no Benefits will be paid].]

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?**
Include the limit selected by the group. *[1]Include either option as standard plan design.* [[1]Limited to $[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].] [[1]Limited per year as follows: • [$[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.] 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].] *[1]Include when Benefits are provided for speech aid and tracheo-esophageal voice devices.* *[2]Include when devices are not included in the annual DME limit.* [[1]Benefits 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 [[2]not] included in the annual limits stated above.]	***[Network]*** [[50 - 100]%]	[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?**
	[Non-Network] [[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?**
Include when benefit is limited. [Limited to $[100 - 5,000] per year.] **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. *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.)* [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: • [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.] • [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and*	***Network*** [[50 - 100]%] *Include bracketed provision and select either #1 or #2 if the Copayment is waived.* *[1]Include as standard; [2]Include only to match prior benefit plans.* [100% after you pay a Copayment of $[5 - 500] per visit. [If you are admitted as an inpatient to a Network Hospital [[1]directly from the Emergency room] [[2]within 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.]] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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] *Include for 2-tiered Copayment option.*	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
Nuclear Medicine - Outpatient.] • [Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.] • [Outpatient surgery procedures described under *Surgery - Outpatient*.] • [Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.] *[1]Include bracketed reference to Manipulative treatment when Manipulative treatment benefits are sold.* • [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [*[1]and *Manipulative Treatment]*.]]	[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] *Include for 3-tiered Copayment option.* [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] *Include for 4-tiered Copayment option.* [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]		

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?**
	Include if plan design includes retrospective review of emergency services. [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] ***Non-Network*** Same as Network	Same as Network	Same as Network
[9.] [Hearing Aids]			
Include the limit selected by the group. *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.* [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].]	***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[10.] Home Health Care			
Include if pre-service notification is required. *[1]Include when the Covered Person is responsible for notification for Network Benefits.* *[2]Include applicable reduction in Benefits.* **[Pre-service Notification 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?**
[For [[1]Network and] Non-Network Benefits 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 [[2]50 - 95]% of Eligible Expenses.]			
Include the limit selected by the group. [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.] [Network Benefits are limited to [40 - 200] visits per year and Non-Network Benefits are limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.] *Include when infusion administration only is not included in the limit.* [This visit limit does not include any service which is billed only for the administration of intravenous infusion.]	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[11.] Hospice Care			

Include if pre-service notification is required.

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

[2]Include applicable reduction in Benefits.

[Pre-service Notification Requirement]

[For [[1]Network and] 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 [[2]50 - 95]% of Eligible Expenses.]

Include if pre-admission notification is required.

[In addition, for [[1]Network and] Non-Network Benefits, you must contact us within 24 hours of admission

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] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per day]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[12.] Hospital - Inpatient Stay			

Include when Benefit Activation Program is sold.

[1]Include applicable Benefit level.

[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 [[1]50 - 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 *Customer Care* at the telephone number on your ID card.]

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

[2]Include applicable Benefit level.

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.

Include if pre-admission notification is required.

[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).]

[1]Include heading and row when Designated Network Benefits apply. *Include when enhanced benefits apply*	***[[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?**
to specific inpatient services. *[2]Include when Physician's fees are paid under the facility charge.* [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:] • [The Copayment you pay for the facility charge [[2]and 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 [[2]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].] [You can determine the specific surgical procedures or diagnoses 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.]	[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 - 10,000] per Inpatient Stay]		Occurrence Deductible is satisfied]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

When 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?**
	Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
Include for groups that purchase infertility benefits. **[13]. [Infertility Services]**			
When this benefit is purchased, pre-service notification will always be required. [1]Include applicable reduction in Benefits or no Benefits. **[Pre-service Notification Requirement]** [You must notify us as soon as the possibility of the need for Infertility Services arises. If you fail to notify us as required, [[1]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[1]you will be responsible for paying all charges and no Benefits will be paid].]			
[1]Include heading and row when Designated Network Benefits apply.	***[[1]Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
Include the limit selected by the group. *[1]Include when the maximum benefit is combined with infertility drugs under*	***[Network]*** [[50 - 100]%]	[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?**
the RX rider. [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. [[1]This limit includes Benefits for infertility medications provided under the *Outpatient Prescription Drug Rider*.] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.]	***[Non-Network]*** [[50 - 100]%] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]
[14.] Lab, X-Ray and Diagnostics - Outpatient			
Include when pre-service notification is required for sleep studies. *[1]Include when the Covered Person is responsible for notification for Network Benefits.* *[2]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses.]			
[1]Include heading and row when Designated Network Benefits apply. *Include limit selected by group.* [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 $[5 - 100] per service] ***Network*** [[50 - 100]%] [100% after you pay a	[Yes] [No] [Yes] [No]	[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?**
	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			
Include when pre-service notification is required for CT, PET, MRI, MRA and nuclear medicine. *[1]Include when the Covered Person is responsible for notification for Network Benefits.* *[2]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses.]			
[1]Include heading and row when Designated Network Benefits apply. *Include limit selected by group.* [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]	[Yes] [No]	[Yes] [No]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[25 - 500] per service]	[Yes] [No]	[Yes] [No]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[25 - 500] per service]	[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?**
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.* *[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 exempt from Parity requirements. Include the limit selected by the group.* *When parity does not apply, this first set of separate benefit statements and limits can be used. When parity does apply, delete these benefit and limit statements and use the "Depending upon" provisions further below."*	***[Network]*** *[Inpatient/Intermediate]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No]
Select from these limit options when limits apply only to Mental Health Services described in this section.	*[Outpatient]* [[50 - 100]%]	[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?**
[Inpatient/Intermediate *Mental Health Services* are limited to [10 - 100] days per year.] [Outpatient *Mental Health Services* are limited to [10 - 100] visits per year.] [Non-Network Benefits for Inpatient/Intermediate *Mental Health Services* are limited to [10 - 100] days per year.] [Non-Network Benefits for outpatient *Mental Health Services* are limited to [10 - 100] visits per year.] *Select from these limit options when limits apply to Mental Health Services described in this section combined with Neurobiological Disorders - Autism Spectrum Disorders below.* [Benefits for any combination of *Mental Health Services* described in this section and *Neurobiological Disorders - Autism Spectrum Disorders* described below are limited as follows: • [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*.]	[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] ***[Non-Network]*** *[Inpatient/Intermediate]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No]
Select from these limit options when limits apply to Mental Health Services described in this section combined with Substance Use Disorder Services below. [Benefits for any combination of *Mental Health Services* described in	*[Outpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a	[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?**
this section and *Substance Use Disorder Services* described below are limited as follows: • [10 - 100] days per year for Inpatient/Intermediate *Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Mental Health Services* and *Substance Use Disorder Services*.]	Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.] [100% for visits for medication management]		
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.*	***[Network]*** [Depending upon where the Covered Health Service is provided, Benefits for outpatient *Mental Health Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate *Mental Health Services* will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
	[Non-Network] [Depending upon where the Covered Health Service is provided, Benefits for outpatient *Mental Health Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate *Mental Health Services* will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
Include for groups that purchase mental health benefits. **[17.] [Neurobiological Disorders - Autism Spectrum Disorder 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?**
When this benefit is purchased, prior authorization will always be required. [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 exempt from Parity requirements. Include the limit selected by the group.* *When parity does not apply, this first set of separate benefit statements and limits can be used. When parity does apply, delete these benefit and limit statements and use the "Depending upon" provisions further below."*	***[Network]*** *[Inpatient/Intermediate]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No]
Select from these limit options when limits apply only to Neurobiological Disorders - Autism Spectrum Disorders described in this section. [Inpatient/Intermediate *Neurobiological Disorders -Autism Spectrum Disorders* are limited to [10 - 100] days per year.] [Outpatient *Neurobiological Disorders - Autism Spectrum Disorders* are limited to [10 - 100] visits per year.] [Non-Network Benefits for Inpatient/Intermediate *Neurobiological Disorders -Autism Spectrum Disorders*	*[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]	[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?**
are limited to [10 - 100] days per year.] [Non-Network Benefits for outpatient *Neurobiological Disorders -Autism Spectrum Disorders* are limited to [10 - 100] visits per year.] *Select from these limit options when limits apply to Neurobiological Disorders - Autism Spectrum Disorders described in this section combined with Mental Health Services above.* [Benefits for any combination of *Neurobiological Disorders - Autism Spectrum Disorders* described in this section and *Mental Health Services* described above are limited as follows: • [10 - 100] days per year for Inpatient/Intermediate *Neurobiological Disorders - Autism Spectrum Disorders* and *Mental Health Services*. • [10 - 100] visits per year for outpatient *Neurobiological Disorders - Autism Spectrum Disorders* and *Mental Health Services*.]	***[Non-Network]*** *[Inpatient/Intermediate]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No]
	[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]	[Yes] [No]	[Yes] [No]
Note: *When parity applies, these benefit statements must be used in*	***[Network]***		

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?**
lieu of those options available above to assure that cost sharing will always be equal to medical services.	[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*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
	[Non-Network] [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*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
Include for groups that purchase benefits for obesity surgery. **[18.] [Obesity Surgery]**			
When this benefit is purchased, pre-service notification will always be required. [1]*Include applicable Benefit level.* **[Pre-service Notification Requirement]** [You must notify us [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [1]*Include when the Covered Person is responsible for notification for Network Benefits.* [In addition, for [[1]Network and] Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.]			

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?**
[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]			
[1]Include heading and row when Designated Network Benefits apply. *[2]Include when Designated Network Benefits apply.* *[3]Include when Network Benefits are available.* *[4]Insert the limit selected by the group.* [Any combination of [[2]Designated Network Benefits] [[3], Network Benefits] and Non-Network Benefits is limited to $[[4]50,000 - 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 $[[4]5,000 - 30,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]	***[[1]Designated Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[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 *Schedule of Benefits*.]		
Include when there is not a Network level of benefits available. [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.]	***[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 *Schedule of Benefits*.]		
Include if group purchases benefits for ostomy supplies. **[19.] [Ostomy Supplies]**			

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?**
Include the limit selected by the group. [Limited to $[500 - 25,000] per year.]	***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[20.] Pharmaceutical Products - Outpatient			

Include when notification is required for IV infusions.

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

[2]Include applicable reduction in Benefits.

[Pre-service Notification Requirement]

[For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses.]

Include when notification is required for select Pharmaceutical Products.

[For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses. 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.]

[1]Include heading and row when Designated Network Benefits apply. *Include limit selected by group.* [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 $[5 - 100] per Pharmaceutical Product] *Include when Coinsurance is tiered and select the appropriate number of tiers by plan design.* [[50 - 100]% - Tier 1]	[Yes] [No] [Yes, except when provided during a Physician office visit]	[Yes] [No] [Yes, except when provided during a Physician office visit]

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 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]		
	Network		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product]	[Yes, except when provided during a Physician office visit]	[Yes, except when provided during a Physician office visit]
	Include when Coinsurance is tiered and select the appropriate number of tiers by plan design.		
	[[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]		
	Non-Network		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product]	[Yes, except when provided during a Physician office visit]	[Yes, except when provided during a Physician office visit]
	Include when Coinsurance is tiered and select the appropriate number of tiers by plan design.		

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			
Include when Benefit Activation Program is sold. *[1]Include applicable Benefit level.* **[Benefit Activation Notification Requirement]** [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 [[1]50 - 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 *Customer Care* at the telephone number on your ID card.]			
[1]Include heading and row when Designated Network Benefits apply. *Include when enhanced benefits apply to specific Physician services.* [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:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.]	***[[1]Designated Network]*** [[50 - 100]%]	[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?**
• [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] **[Enhanced Benefits:]** • [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].] [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.]			
[2]Include text if the plan design supports paying non-network benefits for a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist). [[2]Covered Health Services provided by a non-Network facility-based Physician (a non-Network anesthesiologist,	***Network*** [50 - 100]%	[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?**
radiologist, or pathologist) in a Network facility will be paid as Non-Network Benefits.] *[3]Include text if the plan design supports paying non-network benefits for a non-Network consulting Physician, assistant surgeon or surgical assistant.* [[3]Covered 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.]	***Non-Network*** [50 - 100]%	[Yes] [No]	[Yes] [No]
[22.] Physician's Office Services - Sickness and Injury			

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?**
Include when Benefit Activation Program is sold. *[1]Include applicable Benefit level.* **[Benefit Activation Notification Requirement]** [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 [[1]50 - 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 *Customer Care* at the telephone number on your ID card.]			
Include if group chooses to limit benefit. [1]Insert limit selected by group. [Limited to [[1]2 - 10] visits per year.] *[1]Include heading and row when Designated Network Benefits apply.* *Include when enhanced benefits apply to specific physician office services.* [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:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.]	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [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] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
• [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] **[Enhanced Benefits:]** • [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].] [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.]	that year] [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] [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]		
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	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
subject to Coinsurance only.) [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: • [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.] • [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*.] • [Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.] • [Outpatient surgery procedures described under *Surgery - Outpatient*.] • [Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.] *[1]Include bracketed reference to Manipulative treatment when Manipulative treatment benefits are sold.* • [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment].*]]	per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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] [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] ***Non-Network***		

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]%] [100% after you pay a Copayment of $[5 - 100] per visit] [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] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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] [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	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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]		
[1]Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude. [2]If Maternity Services are excluded, Complications of Pregnancy must always be included. **[23.] Pregnancy - [[1]Maternity Services] [[2]Complications of Pregnancy only]**			

[1]Include when benefits are provided for maternity services.

[2]Include when the Covered Person is responsible for notification for Network Benefits.

[3]Include applicable Benefit level.

[[1]Pre-service Notification Requirement]

[[1]For [[2]Network 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 [[3]50 - 95]% of Eligible Expenses.]

[4]Include when benefits are provided for complications of pregnancy only.

[5]Include when the Covered Person is responsible for notification for Network Benefits.

[6]Include applicable Benefit level.

[[4]Pre-service Notification Requirement]

[[4]For [[5]Network 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 [[6]50 - 95]% of Eligible Expenses.]

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.

[1]Include when benefits are provided for maternity services.

[[1]Network]

[3]Include when an annual deductible applies to network benefits.

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?**
	[4Include when Network services in the Physician's office are subject to a Copayment. [[1]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* [[3]except 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]. [[4]For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.] ***[[1]Non-Network]*** *[3Include when an annual deductible applies to non-network benefits.* *[4Include when Non-Network services in the Physician's office are subject to a Copayment.* [[1]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* [[3]except 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]. [[4]For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.] *[2Include when benefits are provided for complications of pregnancy only.* ***[[2]Network]*** [[2]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[[2]Non-Network]*** [[2]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
[24.] Preventive Care Services			
Include when preventive care is limited and select the limit that applies. [Preventive care services are limited to $[100 - 1,000] per year.] **Physician office services** • Well baby and well child care includes, but is limited to, 20	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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 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. No Copayment, Coinsurance or deductible will be applicable to Network or non-Network children's immunizations.	per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available except for children under the age of 19.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available except for children under the age of 19.]

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:	[Non-Network Benefits are not available.] ***Network*** [[50 - 100]%] [100% after you pay a 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 except for children under the age of 19.]	[Yes] [No] [Yes] [No] [Non-Network Benefits are not available except for children under the age of 19.]	[Yes] [No] [Yes] [No] [Non-Network Benefits are not available except for children under the age of 19.]
[25.] Prosthetic Devices and Services			
Include if notification is required. *[1]Include when the Covered Person is responsible for notification for Network Benefits.* *[2]Include when notification applies only to prosthetics that exceed a minimum dollar amount and insert applicable dollar amount.* *[3]Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [For [[1]Network and] Non-Network Benefits you must notify us before obtaining prosthetic devices [[2]that exceed $[1,000 - 5,000] in cost per device]. If you fail to notify us as required, [[3]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[3]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			

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?

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

[2]Include applicable Benefit level.

Pre-service Notification Requirement

For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses.

Include if pre-admission notification is required.

[In addition, for [[1]Network 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).]

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 *Schedule of Benefits*.

Include when group does not purchase benefits for prosthetic devices.

[1]Include when sold with a plan that has an annual deductible and select either "are" or "are not."

[2]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."

[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [[1]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[2]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]

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 *Schedule of Benefits*.

Include when group does not purchase benefits for prosthetic devices. The Benefit level inserted here must be the same as the plan Coinsurance level.

[1]Include when sold with a plan that has an annual deductible and select either "are" or "are not."

[2]Include when sold with a plan that has an out-of-pocket

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 and select either "applies" or "does not apply." [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [[1]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[2]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
Include entire section when rehabilitation services benefit is sold. *[1]Include when Manipulative Treatment benefits are sold.* **[27.] [Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment]]**			
Include when notification is required for any rehabilitation service. *[1]Include when the Covered Person is responsible for notification for Network Benefits.* *[2]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses.]			
Include when per therapy limits apply. *[1]Include when Manipulative Treatment benefits are sold.* *[2]Include when vision therapy benefits are sold.* [Limited per year as follows: • [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.	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
• [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.]] *Include when combined therapy visit limits apply.* *[1]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.* *[2]Include when vision therapy benefits are sold.* [Any combination of physical therapy, occupational therapy, [[1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [[2]and vision therapy] is limited to [10 - 160] visits per year.] *Include when combined therapy dollar limits apply.* *[1]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.* *[2]Include when vision therapy benefits are sold.* [Any combination of physical therapy, occupational therapy, [[1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy,	***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?
cardiac rehabilitation therapy, post-cochlear implant aural therapy, [[2]and vision therapy] is limited to $[750 - 12,000] per year.] *Include when combined therapy visit limits apply separately to network benefits and to non-network benefits.* *[1]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.* *[2]Include when vision therapy benefits are sold.* [Network Benefits for any combination of physical therapy, occupational therapy, [[1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [[2]and vision therapy] are limited to [10 - 160] visits per year.] [Non-Network Benefits for any combination of physical therapy, occupational therapy, [[1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [[2]and vision therapy] are limited to [10 - 160] visits per year.]			
[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			

Include when notification is required for scopic procedures.

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

[2]Include applicable Benefit level.

[Pre-service Notification 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?**
[For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses.]			
[1]Include heading and row when Designated Network Benefits apply.	***[[1]Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	Network [50 - 100]%	[Yes] [No]	[Yes] [No]
	Non-Network [50 - 100]%	[Yes] [No]	[Yes] [No]
[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
[1]Include when the Covered Person is responsible for notification for Network Benefits. *[2]Include applicable Benefit level.*			
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. If you fail to notify us as required, Benefits will be reduced to [[2]50 - 95]% of Eligible Expenses.			
Include if pre-admission notification is required.			
[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).]			
Include limit selected by group. [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.]	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] *Copayment option below identified as #1 to be tied only to either of the options #1 below with an Inpatient Stay maximum.* [[1]100% after you pay a	[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?**
	Copayment of $[50 - 2,000] per Inpatient Stay] [[1]100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 5,000] per Inpatient Stay] *Variable #1 can be used only with options numbered #1 above.* [[1]If 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.] [No Copayment applies if you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility.] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day]	[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?**
	[100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay]		
Include for groups that purchase substance use disorder benefits. **[30.] [Substance Use Disorder Services]**			
When this benefit is purchased, prior authorization will always be required. *[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 exempt from Parity requirements. Include the limit selected by the group.* *When parity does not apply, this first set of separate benefit statements and limits can be used. When parity does apply, delete these benefit and limit statements and use the "Depending upon" provisions further below."*	***[Network]*** *[Inpatient/Intermediate]* [[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	[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?**
	Inpatient Stay]		
Select from these limit options when limits apply only to Substance Use Disorder Services described in this section. [Inpatient/Intermediate *Substance Use Disorder Services* are limited to [10 - 100] days per year.] [Outpatient *Substance Use Disorder Services* are limited to [10 - 100] visits per year.] [Non-Network Benefits for Inpatient/Intermediate *Substance Use Disorder Services* are limited to [10 - 100] days per year.] [Non-Network Benefits for outpatient *Substance Use Disorder Services* are limited to [10 - 100] visits per year.] *Select from these limit options when limits apply to Substance Use Disorder Services described in this section combined with Mental Health Services above.* [Benefits for any combination of *Substance Use Disorder Services* described in this section and *Mental Health Services* described above are limited as follows: • [10 - 100] days per year for Inpatient/Intermediate *Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Mental Health Services* and *Substance Use Disorder Services*.]	*[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] ***[Non-Network]*** *[Inpatient/Intermediate]* [[50 - 100]%]	[Yes] [No] [Yes] [No]	[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?**
	[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]		
	[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]	[Yes] [No]	[Yes] [No]
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.*	***[Network]*** [Depending upon where the Covered Health Service is provided, Benefits for outpatient *Substance Use Disorder Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate *Substance Use Disorder Services* will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
	[Non-Network]		

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 for outpatient *Substance Use Disorder Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate *Substance Use Disorder* Services will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
[31.] Surgery - Outpatient			

Include when Benefit Activation Program is sold.

[1]Include applicable Benefit level.

[Benefit Activation Notification Requirement]

[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 [[1]50 - 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 *Customer Care* at the telephone number on your ID card.]

Include when notification is required.

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

[2]Include applicable Benefit level.

[Pre-service Notification Requirement]

[For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses.]

[1]Include heading and row when Designated Network Benefits apply. *Include provision below when enhanced benefits apply to specific outpatient surgical services.* *[2]Include when Physician's fees are paid under the facility charge.*	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[10 - 1,000] per date of service]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

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?**
[When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as follows:] • [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].] [You can determine the specific surgical procedures 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.]	[100%after you pay a Copayment of $[10 - 1,000] per date of service, to a maximum Copayment of $[10 - 5,000] per year]]		
	Network [[50 - 100]%] [[100% after you pay a Copayment of $[10 - 1,000] per date of service] [100% after you pay a Copayment of $[10 - 1,000] per date of service, to a maximum Copayment of $[10 - 5,000] per year]]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
	Non-Network		

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]%] [100% after you pay a Copayment of $[10 - 1,000] per date of service] [100% after you pay a Copayment of $[10 - 1,000] per date of service, to a maximum Copayment of $[10 - 5,000] per year]]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
Include when group purchases TMJ benefit. This is a mandated benefit in Arkansas. **[32.] [Temporomandibular Joint Services]**			

When this benefit is purchased, pre-service notification will always be required.

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

[2]Include applicable Benefit level.

[Pre-service Notification Requirement]

[For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses.]

Include if pre-admission notification is required.

[In addition, for [[1]Network and] Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions.]

Include the limit selected by the group. [Limited to $[1,000 - 20,000] per year.]	***[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 *Schedule of Benefits*.] ***[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 *Schedule of Benefits*.]
[33.] Therapeutic Treatments - 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?
Include when notification is required. *[1]Include when the Covered Person is responsible for notification for Network Benefits.* *[2]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [For [[1]Network 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 [[2]50 - 95]% of Eligible Expenses.]			
[1]Include heading and row when Designated Network Benefits apply.	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[25 - 100] per treatment]	[Yes] [No]	[Yes] [No]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[25 - 100] per treatment]	[Yes] [No]	[Yes] [No]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[25 - 100] per treatment]	[Yes] [No]	[Yes] [No]
[34.] Transplantation Services			
Pre-service Notification Requirement 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 result, the services are not performed at a Designated Facility, Network Benefits will not be paid. Non-Network Benefits will apply. *[2]Include applicable benefit reduction penalty.* For Non-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 fail to notify us as			

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?**
required, Benefits will be reduced to [[2]50 - 95]% of Eligible Expenses. *Include if pre-admission notification is required.* *[1]Include when the Covered Person is responsible for notification for Network Benefits.* [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).]			
For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits. *Include when Non-Network Benefits are limited and insert the limit selected by the group.* [Non-Network Benefits are limited to $[30,000 - 250,000] per transplant.]	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
[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?**
Include when urgent care services are limited and insert the limit selected by the group. [Limited to $[100 - 5,000] per year.] [Limited to [2 - 10] visits per year.] *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.)* [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: • [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.] • [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*.] • [Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.] • [Outpatient surgery procedures described under *Surgery - Outpatient*.] • [Outpatient therapeutic procedures described under *Therapeutic Treatments -*	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
Outpatient.] *[1]Include bracketed reference to Manipulative treatment when Manipulative treatment benefits are sold.* • [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [[1]*and *Manipulative Treatment]*.]]	***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]
Include when group purchases benefits for vision exams. **[36.] [Vision Examinations]**			
[Limited to [1 exam] [[2-3] exams] per year.] [Limited to [1 exam] [[2-3] exams]	***[Network]*** [[50 - 100]%]	[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?**
every [2 - 3] years.]	[100% after you pay a Copayment of [$5 - 75] per visit] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of [$5 - 75] per visit] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]
Include when group purchases benefits for wigs. **[37.] [Wigs]**			
Include the limit selected by the group. [Limited to $[100 - 1,000] per year.] [Limited to $[100 - 5,000] every [24 - 36] months.]	***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
Additional Benefits Required By Arkansas Law			
[38.] Dental Services - Anesthesia and Hospitalization			
Pre-service Notification Requirement Any applicable notification requirements will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.			
[1]Include heading and row when Designated Network Benefits apply	[[1]***Designated Network***] [Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] ***Network*** Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*. ***Non-Network*** Benefits will be the same as those stated under *Hospital -*		

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?**
	Inpatient Stay in this *Schedule of Benefits*.		
[39.] In Vitro Fertilization Services			
[1]Include applicable Benefit level.			
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.			
[1]Include heading and row when Designated Network Benefits apply Limited to a lifetime maximum of $15,000.	***[[1]Designated Network]*** [50 - 100%] ***Network*** [50 - 100%] ***Non-Network*** [[50 - 100]%] [Non-Network Benefits are not available.]	*[1]Include heading and row when Designated Network Benefits apply* Limited to a lifetime maximum of $15,000.	***[[1]Designated Network]*** [50 - 100%] ***Network*** [50 - 100%] ***Non-Network*** [[50 - 100]%] [Non-Network Benefits are not available.]
[41.] Medical Foods			
	[1]Include when group purchases the Outpatient Prescription Drug Rider. ***Network*** Depending upon where the Covered Health Service is provided, Benefits will be [50 - 100]% [[1]or as provided under the *Outpatient Prescription Drug Rider*]. ***Non-Network*** Same as Network	[Yes] [No] Same as	[Yes] [No] Same as Network

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?**
		Network	
Include ONLY when group purchases plan with MH full parity. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. **[[42.] Mental Health Services - Inpatient and Intermediate]**			
When this benefit is purchased, prior authorization will always be required. **[Prior Authorization Requirement]** You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.			
	[*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 *Schedule of Benefits*.**]** **[*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 *Schedule of Benefits*.**]**		
Include ONLY when group purchases plan with MH full parity. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. **[[43.] Mental Health Services - Outpatient]**			
Include authorization language only for groups that elect the "Employer Coverage" option. Delete authorization language for groups that elect the "National Service Center" option. **[Prior Authorization Requirement]** You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.			
	[*Network* Depending upon where the Covered Health Service is provided,		

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 each Covered Health Service category in this *Schedule of Benefits*.**]** **[*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 *Schedule of Benefits*.**]**		
Mandated offer in Arkansas. **[[42.] 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 *Schedule of Benefits*.]	***[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 *Schedule of Benefits*.]		
[Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*.]	***[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 *Schedule of Benefits*.]		
Include ONLY when group purchases plan with inpatient/intermediate 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. **[[44.] Substance Abuse Services - Inpatient and Intermediate]**			
When this benefit is purchased, prior authorization will always be required. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
Include the limit selected by the group. [Limited to [10 - 100] days per year.] [Non-Network Benefits are limited to [10 - 100] days per year.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment	[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?**
	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]		
	[Non-Network] [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No]
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. **[[45.] Substance Abuse 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?
Include authorization language only for groups that elect the "Employer Coverage" option. Delete authorization language for groups that elect the "National Service Center" option.			
[Prior Authorization Requirement] [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
Include the limit selected by the group. [Limited to [10 - 100] visits per year.] [Non-Network Benefits are limited to [10 - 100] visits per year.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit]	*Include the limit selected by the group.* [Limited to [10 - 100] visits per year.] [Non-Network Benefits are limited to [10 - 100] visits per year.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit]
[[46.] Orthotic Devices and Services			
Include if notification is required. *1Include when notification applies only to prosthetics that exceed a minimum dollar amount and insert applicable dollar amount.* *2Include applicable reduction in Benefits or no Benefits.*			
[Pre-service Notification Requirement] [For Non-Network Benefits you must notify us before obtaining prosthetic devices [1that exceed $[1,000 -			

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?**
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].]			
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

[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 [[1]Designated 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, [[1]Mental Illness,] [[2]mental 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 [[1]Designated Network Benefits and] Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a [[1]Designated 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.

  - **[**[1]For 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.

  - **[**[2]Fee(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.

[1]Always 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 [[1]through 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 [[1]when 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 [[1]over $[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 [[1]over $[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.]

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

- Hospital inpatient care - all scheduled admissions [[1]and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery] [[2]and 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 [[1]over$[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. [1]Include if notification applies only to prosthetics that exceed a specific dollar amount and insert appropriate dollar amount.

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

[1]Include 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. [1]Include when Manipulative Treatment is included in the rehabilitation services benefit.

- [Rehabilitation services [[1]and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [[1]Manipulative 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, [[1]Mental Illness,] [[2]mental 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. [1]Include when MH benefits are sold. [2]Include when SUD benefits are sold. [3]Include when both MH and SUD benefits are sold. [1-A]Include when benefits for Neurobiological Disorders - Autism Spectrum Disorders are sold.

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

[[[1]Mental Health Services [[1-A](including psychiatric services for Autism Spectrum Disorders)]] [[3]and] [[2]Substance 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 [[1]Mental Health Services] [[3]or] [[2]Substance 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 Coordination[SM]]

[When we are notified as required, we will work with you to implement the Care Coordination[SM] 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	
[1]*Include when an Outpatient Prescription Drug Rider is sold and the Annual Deductible applies to any combination of medical and RX benefits.* [2]*Include when an Outpatient Prescription Drug Rider with separate Copayments for preventive medications is sold and the Annual Deductible does not apply to preventive medications.* [3]*Include when an Outpatient Prescription Drug Rider is sold and when the Annual Deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the Annual Deductible.* The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. [[1]The 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*. [[2]Benefits for Outpatient Prescription Drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [[3]Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the *Outpatient Prescription Drug Rider* are not subject to payment of the Annual Deductible.] *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*	*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.* [No Annual Deductible.]

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.* [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. [1]Include 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. [[1]This 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.]	
Include only when a per occurrence deductible applies. **[Per Occurrence Deductible]**	
[The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following:	*Include when a per occurrence deductible applies to CHD surgery benefits.* [CHD surgery - Inpatient Stay: [$100 - 1,000] per day.] [CHD surgery - Inpatient Stay: [$100 -

• The applicable Per Occurrence Deductible. • The Eligible Expense.]	2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to inpatient hospital benefits.* [Hospital - Inpatient Stay: [$100 - 1,000] per day.] [Hospital - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to outpatient surgery benefits.* [Surgery - Outpatient: [$10 - 1,000] per date of service.] *Include when a per occurrence deductible applies to inpatient transplant benefits.* [Transplant - Inpatient Stay: [$100 - 1,000] per day.] [Transplant - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.]
Out-of-Pocket Maximum	

[1]Include when OOPM includes the Annual Deductible. *[2]Include when OOPM includes the Per Occurrence Deductible.* *[3]Include when OOPM includes Copayments.* *[4]Include when an Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX* The maximum you pay per year for [[1]the Annual Deductible,] [[2]the Per Occurrence Deductible,] [[3]Copayments] [[1-2-3]or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [[4]The 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*.] *[5]Include only when the plan design does not apply all Copayments/Coinsurance to the OOPM.* [[5]Copayments 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 sold and Copayments/Coinsurance do not apply to the overall OOPM.* • [Copayments or Coinsurance for Covered Health Services provided under the *Outpatient Prescription Drug Rider*.]	*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 include the Per Occurrence Deductible.] *Include when there is no OOPM.* [No Out-of-Pocket Maximum.]
Maximum Policy Benefit	

The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Policy.	[$[1,000,000 - 10,000,000] per Covered Person.] [No Maximum Policy Benefit.]
Include only when an annual maximum benefit applies. **[Annual Maximum Benefit]**	
[The maximum amount we will pay for Benefits during the year.]	[$[2,000 - 500,000] per Covered Person.]

Copayment

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.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

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 [[1]a 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] [[3]a 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 [[1]a 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] [[3]a 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?
Include for groups that purchase benefits for acupuncture services. **1. [Acupuncture Services]**			
Include the limit selected by the group. [Limited to [10 - 100] visits per year.] [Limited to [10 - 100] visits per year, not to exceed $[100 - 5,000] in Eligible Expenses per year.] [Limited to $[100 - $5,000] in Eligible Expenses per year.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[2.] Ambulance Services			
Always include Pre-service Notification Requirement except when notification is not required for any service. **[Pre-service Notification Requirement]** [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.]			
Emergency Ambulance *Include the limit selected by the group.* [Ground ambulance limited to $[500 - 5,000] per year.]	*Ground Ambulance:* [50 - 100]%	[Yes] [No]	[Yes] [No]
Include the limit selected by the group. [Air ambulance limited to $[1,000 - 10,000] per year.]	*Air Ambulance:* [50 - 100]%	[Yes] [No]	[Yes] [No]
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	*Ground Ambulance:* [50 - 100]%	[Yes] [No]	[Yes] [No]
	Air Ambulance: [50 - 100]%	[Yes] [No]	[Yes] [No]
Include for groups that purchase benefits for clinical trials. **[3.] [Clinical Trials]**			
Always include Pre-service Notification Requirement except when notification is not required for any service. **[Pre-service Notification 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?
[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 *Schedule of Benefits*.	[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*.]		
Include for groups that purchase benefits for congenital heart disease services. **[4.] [Congenital Heart Disease Surgeries]**			
Include when notification is required. *[1]Include applicable reduction in 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 [[1]50 - 95]% of Eligible Expenses].			
Include when Benefits are limited and insert the limit selected by the group. [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]
Include for groups that purchase benefits for accident-related dental services. **[5.] [Dental Services - Accident Only]**			
Include when pre-service notification is required. *[1]Include applicable reduction in Benefits or no Benefits.* **[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			
Always include Pre-service Notification Requirement except when notification is not required for any service.			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[1]Include when the durable medical equipment benefit is sold. *[2]Include when the durable medical equipment benefit is not sold.* *[3]Include when notification applies only to equipment that exceeds a minimum dollar amount and insert applicable dollar amount.* *[4]Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [You must notify us before obtaining any [[1]Durable Medical Equipment] [[2]diabetes equipment] for the management and treatment of diabetes [[3]that 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, [[4]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[4]you will be responsible for paying all charges and no Benefits will be paid].]			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	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 *Schedule of Benefits*.		
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment*. *Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.* [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].]	*[1]Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.* [[1]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*.] *[2]Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold.* *[3]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[4]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[2]For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [[3]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[4]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[5]Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold.* *[6]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[7]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[5]For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [[6]and Benefits [are] [are not] subject to payment of		

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	the Annual Deductible]. [[7]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[8]Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold.* *[9]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[10]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[8]For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [[9]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[10]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
Include for groups that purchase benefits for DME. **[7.] [Durable Medical Equipment]**			
Always include Pre-service Notification Requirement except when notification is not required for any service. *[1]Include when notification applies only to DME that exceeds a minimum dollar amount and insert applicable dollar amount.* *[2]Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [You must notify us before obtaining any Durable Medical Equipment [[1]that 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, [[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].]			
Include the limit selected by the group. *[1]Include either option as standard plan design.* [[1]Limited to $[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].] [[1]Limited per year as follows: • [$[500 - 10,000] in Eligible Expenses for Tier 1.Tier 1 includes disposable supplies necessary for the effective use of covered Durable Medical	[[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?
Equipment.] • [$[10,001 - 25,000] in Eligible Expenses for Tier 2.] • [$[25,001 - 100,000] in Eligible Expenses for Tier 3.] 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].] *[1]Include when Benefits are provided for speech aid and tracheo-esophageal voice devices.* *[2]Include when devices are not included in the annual DME limit.* [[1]Benefits 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 [[2]not] included in the annual limits stated above.]			
[8.] Emergency Health Services - Outpatient			
Include when benefit is limited. [Limited to $[100 - 5,000] per year.]	[50 - 100]%	[Yes] [No]	[Yes] [No]
Include as standard only for groups of 15+. **[9.] [Hearing Aids]**			
Include the limit selected by the group. *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.* [Limited to $[500 - 5,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[two-	[[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			
Include if pre-service notification is required. *[1]Include applicable reduction in Benefits.* **[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.]			
Include the limit selected by the group. [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.] *Include when infusion administration only is not included in the limit.* [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			
Include if pre-service notification is required. *[1]Include applicable reduction in Benefits.* **[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.] *Include if pre-admission notification is required.* [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			
Always include Pre-service Notification Requirement except when notification is not required for any service. *[1]Include applicable Benefit level.* **[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?
reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [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).]			
	[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
Include for groups that purchase infertility benefits. **[13]. [Infertility Services]**			
Always include Pre-service Notification Requirement except when notification is not required for any service. *[1]Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [You must notify us as soon as the possibility of the need for Infertility Services arises. If you fail to notify us as required, [[1]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[1]you will be responsible for paying all charges and no Benefits will be paid].]			
Include the limit selected by the group. *[1]Include when the maximum benefit is combined with infertility drugs under the RX rider.* [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. [[1]This limit includes Benefits for infertility medications provided under the *Outpatient Prescription Drug Rider*.] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[14.] Lab, X-Ray and Diagnostics - Outpatient			
Include when pre-service notification is required for sleep studies. *[1]Include applicable reduction in Benefits.*			

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 [[1]50 - 95]% of Eligible Expenses.]			
Include limit selected by group. [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			
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]** [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 [[1]50 - 95]% of Eligible Expenses.]			
Include limit selected by group. [Limited to $[100 - 5,000] per year.]	[50 - 100]%	[Yes] [No]	[Yes] [No]
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.* *[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*	*[Inpatient/Intermediate]* [[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?
exempt from Parity requirements. Include the limit selected by the group. *When parity does not apply, this first set of separate benefit statements and limits can be used. When parity does apply, delete these benefit and limit statements and use the "Depending upon" provisions further below."*			
Select from these limit options when limits apply only to Mental Health Services described in this section. [Inpatient/Intermediate *Mental Health Services* are limited to [10 - 100] days per year.] [Outpatient *Mental Health Services* are limited to [10 - 100] visits per year.] *Select from these limit options when limits apply to Mental Health Services described in this section combined with Neurobiological Disorders - Autism Spectrum Disorders below.* [Benefits for any combination of *Mental Health Services* described in this section and *Neurobiological Disorders - Autism Spectrum Disorders* described below are limited as follows: • [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*.] *Select from these limit options when limits apply to Mental Health Services described in this section combined with Substance Use Disorder Services below.* [Benefits for any combination of *Mental Health Services* described in this section and *Substance Use*	*[Outpatient]* [[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?
Disorder Services described below are limited as follows: • [10 - 100] days per year for Inpatient/Intermediate *Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Mental Health Services* and *Substance Use Disorder Services*.]			
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.*	[Depending upon where the Covered Health Service is provided, Benefits for outpatient *Mental Health Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate *Mental Health Services* will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
Include for groups that purchase mental health benefits. **[17.] [Neurobiological Disorders - Autism Spectrum Disorder Services]**			
When this benefit is purchased, prior authorization will always be required. [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 exempt from Parity requirements. Include the limit selected by the group.* *When parity does not apply, this first set of separate benefit statements and*	*[Inpatient/Intermediate]* [[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?
limits can be used. When parity does apply, delete these benefit and limit statements and use the "Depending upon" provisions further below."			
Select from these limit options when limits apply only to Neurobiological Disorders - Autism Spectrum Disorders described in this section. [Inpatient/Intermediate *Neurobiological Disorders -Autism Spectrum Disorders* are limited to [10 - 100] days per year.] [Outpatient *Neurobiological Disorders - Autism Spectrum Disorders* are limited to [10 - 100] visits per year.] *Select from these limit options when limits apply to Neurobiological Disorders - Autism Spectrum Disorders described in this section combined with Mental Health Services above.* [Benefits for any combination of *Neurobiological Disorders - Autism Spectrum Disorders* described in this section and *Mental Health Services* described above are limited as follows: • [10 - 100] days per year for Inpatient/Intermediate *Neurobiological Disorders - Autism Spectrum Disorders* and *Mental Health Services*. • [10 - 100] visits per year for outpatient *Neurobiological Disorders - Autism Spectrum Disorders* and *Mental Health Services*.]	*[Outpatient]* [[50 - 100]%]	[Yes] [No]	[Yes] [No]
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.*	[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*.] *Include when outpatient visits for medication management are paid at 100%.*		

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%.]		
Include for groups that purchase benefits for obesity surgery. **[18.] [Obesity Surgery]**			
Always include Pre-service Notification Requirement except when notification is not required for any service. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [You must notify us [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [In addition, you must contact us 24 hours before admission for an Inpatient Stay.] **[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.]**			
Include when group chooses to limit benefit. *[1]Insert the limit selected by the group.* [Limited to $[[1]50,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]	[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*.]		
Include if group purchases benefits for ostomy supplies. **[19.] [Ostomy Supplies]**			
Include the limit selected by the group. [Limited to $[500 - 25,000] per year.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[20.] Pharmaceutical Products - Outpatient			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Include when notification is required for IV infusions. *[1]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.] *Include when notification is required for select Pharmaceutical Products.* [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 [[1]50 - 95]% of Eligible Expenses. 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 limit selected by group. [Limited to $[100 - 5,000] per year.]	[[50 - 100]%] *Include when Coinsurance is tiered and select the appropriate number of tiers by plan design.* [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]	[Yes] [No] [Yes, except when provided during a Physician office visit]	[Yes] [No] [Yes, except when provided during a Physician office visit]
[21.] Physician Fees for Surgical and Medical Services			
	[50 - 100]%	[Yes] [No]	[Yes] [No]
[22.] Physician's Office Services - Sickness and Injury			
Include if group chooses to limit benefit. [1]Insert limit selected by group. • 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	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [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	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years. No Copayment, Coinsurance or deductible will be applicable to Network or Non-Network children's immunizations.	office visit] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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] [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]		
[1]Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude. [2]If Maternity Services are excluded, Complications of Pregnancy must always be included. **[23.] Pregnancy - [[1]Maternity Services] [[2]Complications of Pregnancy only]**			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Always include Pre-service Notification Requirement except when notification is not required for any service. *[1]Include when benefits are provided for maternity services.* *[2]Include applicable Benefit level.* **[[1]Pre-service Notification Requirement]** [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 [[2]50 - 95]% of Eligible Expenses.] *[3]Include when benefits are provided for complications of pregnancy only.* *[4]Include applicable Benefit level.* **[[4]Pre-service Notification Requirement]** [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 [[4]50 - 95]% of Eligible Expenses.] *Always include notification statement except when notification is not required for any service.* **[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.]**			
	[1]Include when benefits are provided for maternity services. *[3]Include when an annual deductible applies.* *[4]Include when services in the Physician's office are subject to a Copayment.* [[1]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* [[3]except 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]. [[4]For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.] *[2]Include when benefits are provided for complications of pregnancy only.* [[2]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
[24.] Preventive Care Services			
Include when preventive care is limited and select the limit that applies. [Preventive care services are limited to $[100 - 1,000] per year.]	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit]	[Yes] [No] [Yes, when Benefits are subject to	[Yes] [No] [Yes, when Benefits are subject to

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Physician office services [Limited to [2 - 10] visits per year.]	[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] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]	Coinsurance]	Coinsurance]
Lab, X-ray or other preventive tests:	[[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service]	[Yes] [No]	[Yes] [No]
Include when group purchases benefits for prosthetic devices. Prosthetics is a mandated benefit in Arkansas. **[25.] Prosthetic Devices and Services**			
Include if notification is required. *[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]** [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.	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
[26.] Reconstructive Procedures			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Always include Pre-service Notification Requirement except when notification is not required for any service. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [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).]			
	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*. *Include when group does not purchase benefits for prosthetic devices.* *[1]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[2]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [[1]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[2]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
Include entire section when rehabilitation services benefit is sold. *[1]Include when Manipulative Treatment benefits are sold.* **[27.] [Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment]]**			
Include when notification is required for any rehabilitation service. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.]			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Include when per therapy limits apply. *[1]Include when Manipulative Treatment benefits are sold.* *[2]Include when vision therapy benefits are sold.* [Limited per year as follows: • [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.]] *Include when combined therapy visit limits apply.* *[1]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.* *[2]Include when vision therapy benefits are sold.* [Any combination of physical therapy, occupational therapy, [[1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [[2]and vision therapy] is limited to [10 - 160] visits per year.] *Include when combined therapy dollar*	[[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?
limits apply. *[1]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.* *[2]Include when vision therapy benefits are sold.* [Any combination of physical therapy, occupational therapy, [[1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [[2]and vision therapy] is limited to $[750 - 12,000] per year.] Include when combined therapy visit limits apply separately to network benefits and to non-network benefits.			
[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
Include when notification is required for scopic procedures. *[1]Include applicable Benefit level.* **[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 [[1]50 - 95]% of Eligible Expenses.]			
	[50 - 100]%	[Yes] [No]	[Yes] [No]
[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Always include Pre-service Notification Requirement except when notification is not required for any service. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.]			

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Include if pre-admission notification is required. [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).]			
Include limit selected by group. [Limited to [40 - 180] days per year.]	[50 - 100]%	[Yes] [No]	[Yes] [No]
Include for groups that purchase substance use disorder benefits. **[30.] [Substance Use Disorder Services]**			
When this benefit is purchased, prior authorization will always be required. [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 exempt from Parity requirements. Include the limit selected by the group.* *When parity does not apply, this first set of separate benefit statements and limits can be used. When parity does apply, delete these benefit and limit statements and use the "Depending upon" provisions further below."*	*[Inpatient/Intermediate]* [[50 - 100]%]	[Yes] [No]	[Yes] [No]
Select from these limit options when limits apply only to Substance Use Disorder Services described in this section. [Inpatient/Intermediate *Substance Use Disorder Services* are limited to [10 - 100] days per year.] [Outpatient *Substance Use Disorder Services* are limited to [10 - 100] visits per year.]	*[Outpatient]* [[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?
Select from these limit options when limits apply to Substance Use Disorder Services described in this section combined with Mental Health Services above. [Benefits for any combination of *Substance Use Disorder Services* described in this section and *Mental Health Services* described above are limited as follows: • [10 - 100] days per year for Inpatient/Intermediate *Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Mental Health Services* and *Substance Use Disorder Services*.]			
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.*	[Depending upon where the Covered Health Service is provided, Benefits for outpatient *Substance Use Disorder Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate *Substance Use Disorder Services* will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
[31.] Surgery - Outpatient			
Include when notification is required. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [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 possible. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.]			
	[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible 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?
			satisfied]
Include when group purchases TMJ benefit. This is a mandated benefit in Arkansas. **[32.] [Temporomandibular Joint Services]**			
Always include Pre-service Notification Requirement except when notification is not required for any service. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [In addition, you must contact us 24 hours before admission for scheduled inpatient admissions.]			
Include the limit selected by the group. [Limited to $[1,000 - 20,000] per year.]	[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
[33.] Therapeutic Treatments - Outpatient			
Include when notification is required. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.]			
	[50 - 100]%	[Yes] [No]	[Yes] [No]
[34.] Transplantation Services			
Always include notification requirement except when notification is not required for any service. *[1]Include applicable Benefit level.* [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 [[1]50 - 95]% of Eligible Expenses. *Include if pre-admission notification is required.* [In addition, you must contact us 24 hours before admission for scheduled admissions 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?
reasonably possible for non-scheduled admissions (including Emergency admissions).]			
	[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
[35.] Urgent Care Center Services			
Include when urgent care services are limited and insert the limit selected by the group. [Limited to $[100 - 5,000] per year.] [Limited to [2 - 10] visits per year.]	[50 - 100]%	[Yes] [No]	[Yes] [No]
Include when group purchases benefits for vision exams. **[36.] [Vision Examinations]**			
[Limited to [1 exam] [[2-3] exams] per year.] [Limited to [1 exam] [[2-3] exams] every [2 - 3] years.]	[[50 - 100]%] [100% after you pay a Copayment of [$5 - 75] per visit]	[Yes] [No]	[Yes] [No]
Include when group purchases benefits for wigs. **[37.] [Wigs]**			
Include the limit selected by the group. [Limited to $[100 - 1,000] per year.] [Limited to $[100 - 5,000] every [24 - 36] months.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
Additional Benefits Required By Arkansas Law			
[38.] Dental Services - Anesthesia and Hospitalization			
Always include Pre-service Notification Requirement except when notification is not required for any service. **[Pre-service Notification Requirement]** [Any applicable notification requirements will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.]			
	Benefits will be the same as those stated under *Hospital - Inpatient*		

	Stay in this *Schedule of Benefits*.		
[39.] In Vitro Fertilization Services			
Always include Pre-service Notification Requirement except when notification is not required for any service. *[1]Include applicable Benefit level.* **[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			
	[1]Include when group purchases the Outpatient Prescription Drug Rider. Depending upon where the Covered Health Service is provided, Benefits will be [50 - 100]% [[1]or as provided under the *Outpatient Prescription Drug Rider*].	[Yes] [No]	[Yes] [No]
Include ONLY when group purchases plan with MH full parity. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. **[[41.] Mental Health Services - Inpatient and Intermediate]**			
When this benefit is purchased, prior authorization will always be required except when notification/prior authorization is not required for any service. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
	[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*.]		
Include ONLY when group purchases plan with MH full parity. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing.			

[[42.] Mental Health Services - Outpatient]			
Include authorization language only for groups that elect the "Employer Coverage" option. Delete authorization language for groups that elect the "National Service Center" option. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
	[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*.]		
Mandated offer in Arkansas. **[[43.] Musculoskeletal Disorders of the Face, Neck or Head]**			
Always include Pre-service Notification Requirement except when notification is not required for any service. **[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 *Schedule of Benefits*.]			
	[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*.]		
Include ONLY when group purchases plan with inpatient/intermediate 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. **[[44.] Substance Abuse Services - Inpatient and Intermediate]**			
When this benefit is purchased, prior authorization will always be required except when notification/prior authorization is not required for any service. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
Include the limit selected by the group. [Limited to [10 - 100] days per year.]	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
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. **[[45.] Substance Abuse Services - Outpatient]**			
Include authorization language only for groups that elect the "Employer Coverage" option. Delete authorization language for groups that elect the "National Service Center" option. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
Include the limit selected by the group. [Limited to [10 - 100] visits per year.] **[[46.] Orthotic Devices and Services**	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
Include if notification is required. *[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 replacements are limited to a single purchase of each type of orthotic device every three years	[[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.

[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, [[1]Mental Illness,] [[2]mental 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]:

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

- **[**[1]For 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, include the following and delete PHCS provisions.*

- **[**[2]Fee(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.

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

[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.

You can choose to receive [[1]Designated 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.]

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

[2]Include and delete #1if 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.]

[2]Include 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. [[2]Covered 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.]

[1]Always 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 [[1]through 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 [[1]when 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 [[1]over $[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 [[1]over $[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.]

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

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

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

- Orthotics devices [[1]over$[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.]

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

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

[1]Include 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. [1]Include when Manipulative Treatment is included in the rehabilitation services benefit.

- [Rehabilitation services [[1]and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [[1]Manipulative 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, [[1]Mental Illness,] [[2]mental 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. [1]Include when MH benefits are sold. [2]Include when SUD benefits are sold. [3]Include when both MH and SUD benefits are sold. [1-A]Include when benefits for Neurobiological Disorders - Autism Spectrum Disorders are sold.

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

[[[1]Mental Health Services [[1-A](including psychiatric services for Autism Spectrum Disorders)]] [[3]and] [[2]Substance 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 [[1]Mental Health Services] [[3]or] [[2]Substance 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 Coordination[SM]

When we are notified as required, we will work with you to implement the Care Coordination[SM] 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 [[1]Designated 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]Include when the Annual Deductible applies only to Non-	*[1]Include separate Network and Non-*

Network Benefits.

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

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

[4]Include when an Outpatient Prescription Drug Rider is sold and when the Annual Deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the Annual Deductible.

[5]Include 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.

[6]Include 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 [[1]Non-Network] Benefits. [[2]The 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*. [[3]Benefits for Outpatient Prescription Drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [[4]Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the *Outpatient Prescription Drug Rider* are not subject to payment of the Annual Deductible.] [[5]The Annual Deductible for [[6]Designated 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.

[2]Include 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. [1]Include 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. [[1]This 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).

	[$[0 - 15,000] per Covered Person, not to exceed $[0 - 45,000] for all Covered Persons in a family.]
Include only when a per occurrence deductible applies. **[Per Occurrence Deductible]**	
[The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Eligible Expense.]	*[1]Include when Designated Network Benefits apply to either category.* ***[[[1]Designated Network and] Network]*** *Include when a per occurrence deductible applies to CHD surgery benefits.* [CHD surgery - Inpatient Stay: [$100 - 1,000] per day.] [CHD surgery - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to inpatient hospital benefits.* [Hospital - Inpatient Stay: [$100 - 1,000] per day.] [Hospital - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to outpatient surgery benefits.* [Surgery - Outpatient: [$10 - 1,000] per date of service.] *Include when a per occurrence deductible applies to inpatient transplant benefits.* [Transplant - Inpatient Stay: [$100 - 1,000] per day.] [Transplant - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] ***[Non-Network]*** *Include when a per occurrence deductible applies to CHD surgery benefits.* [CHD surgery - Inpatient Stay: [$100 - 1,000] per day.] [CHD surgery - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to inpatient hospital*

	benefits. [Hospital - Inpatient Stay: [$100 - 1,000] per day.] [Hospital - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.] *Include when a per occurrence deductible applies to outpatient surgery benefits.* [Surgery - Outpatient: [$50 - 800] per date of service.] *Include when a per occurrence deductible applies to inpatient transplant benefits.* [Transplant - Inpatient Stay: [$100 - 1,000] per day.] [Transplant - Inpatient Stay: [$100 - 2,000] per Inpatient Stay.]
Out-of-Pocket Maximum	

[1]Include when OOPM includes the Annual Deductible.

[2]Include when OOPM includes the Per Occurrence Deductible.

[3]Include when OOPM includes Copayments.

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

[5]Include 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.

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

The maximum you pay per year for [[1]the Annual Deductible,] [[2]the Per Occurrence Deductible,] [[3]Copayments] [[1-2-3]or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [[4]The 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*.] [[5]The Out-of-Pocket Maximum for [[6]Designated 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*.]

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

[[7]Copayments 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

[1]Include 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.

[2]Include 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

sold and Copayments/Coinsurance do not apply to the overall OOPM. • [Copayments or Coinsurance for Covered Health Services provided under the *Outpatient Prescription Drug Rider*.]	include the Per Occurrence Deductible.] *Include when there is no OOPM.* [No Out-of-Pocket Maximum.] ***[[1]Non-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 include the Per Occurrence Deductible.] *Include when there is no OOPM.* [No Out-of-Pocket Maximum.] *[3]Include combined Network and Non-Network heading and statements below*

	when OOPM provision applies 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.* ***[[3][2]Designated Network,] Network and Non-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 include the Per Occurrence Deductible.]

	Include when there is no OOPM. [No Out-of-Pocket Maximum.]
Maximum Policy Benefit	
The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Policy.	*[1]Include when separate Network and Non-Network Maximums apply.* *[2]Include when Designated Network Benefits apply to any category.* ***[[1][2]Designated Network and] Network]*** [$[1,000,000 - 10,000,000] per Covered Person.] [No Maximum Policy Benefit.] ***[[1]Non-Network]*** [$[1,000,000 - 10,000,000] per Covered Person.] [No Maximum Policy Benefit.] *[3]Include when combined Network and Non-Network Maximums applies.* ***[[3][2]Designated Network,] Network and Non-Network]*** [$[1,000,000 - 10,000,000] per Covered Person.]
Include only when an annual maximum benefit applies. **[Annual Maximum Benefit]**	

[The maximum amount we will pay for Benefits during the year.]	*[1]Include when separate Network and Non-Network Maximums apply.* *[2]Include when Designated Network Benefits apply to any category.* ***[[1][2]Designated Network and] Network]*** [$[2,000 - 500,000] per Covered Person.] ***[[1]Non-Network]*** [$[2,000 - 500,000] per Covered Person.] *[3]Include when combined Network and Non-Network Maximums applies.* ***[[3][2]Designated Network,] Network and Non-Network]*** [$[2,000 - 500,000] per Covered Person.]
Copayment	
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. Please note that for Covered Health Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Eligible Expense. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	

Benefit Limits

Include when benefit plan design has no additional limits.

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

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

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

Include when orthopedic surgery is limited.

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

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

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

- [Benefits for Covered Health Services for orthopedic surgery for joint replacement are limited to [[1]a 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] [[3]a 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 [[1]a 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] [[3]a 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?**
Include for groups that purchase benefits for acupuncture services. **1. [Acupuncture Services]**			
Include the limit selected by the group. [Limited to [10 - 100] visits per year.] [Limited to [10 - 100] visits per year, not to exceed $[100 - 5,000] in Eligible Expenses per year.] [Limited to $[100 - $5,000] in Eligible Expenses per year.] [This limit applies to Network Benefits only. Non-Network Benefits are not available.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available.]
[2.] Ambulance Services			
Pre-service Notification Requirement 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.			
Emergency Ambulance	***Network***		

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?**
Include the limit selected by the group. [Ground ambulance limited to $[500 - 5,000] per year.]	*Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 - 1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]]	[Yes] [No]	[Yes] [No]
Include the limit selected by the group. [Air ambulance limited to $[1,000 - 10,000] per year.]	*Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] [100% after you pay a Copayment of $[2,500 - 10,000] per day] [100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]]	[Yes] [No]	[Yes] [No]
	Non-Network Same as Network	Same as Network	Same as Network
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	***Network*** *Ground Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 300] per transport] [100% after you pay a Copayment of $[300 -	[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?**
	1,000] per day] [100% after you pay a Copayment of $[300 - 1,000] per day, up to a per day maximum of $[300 - 1,000]] *Air Ambulance:* [[50 - 100]%] [100% after you pay a Copayment of $[25 - 2,500] per transport] [100% after you pay a Copayment of $[2,500 - 10,000] per day] [100% after you pay a Copayment of $[2,500 - 10,000] per day, up to a per day maximum of $[2,500 - 10,000]] ***Non-Network*** Same as Network	[Yes] [No] Same as Network	[Yes] [No] Same as Network
Include for groups that purchase benefits for clinical trials. **[3.] [Clinical Trials]**			
When Clinical Trials benefit is included, pre-service notification requirement will always apply. **[Pre-service Notification Requirement]** [You must notify us as soon as the possibility of participation in a clinical trial arises. If you don't notify us, you will be responsible for paying all charges and no Benefits will be paid.]			
[Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*. Benefits are available when the Covered Health Services are provided by either Network or non-Network	***[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 *Schedule of Benefits*.] ***[Non-Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each		

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?**
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.)]	Covered Health Service category in this *Schedule of Benefits*.]		
Include for groups that purchase benefits for congenital heart disease services. **[4.] [Congenital Heart Disease Surgeries]**			
Include if pre-service notification is required. *[1]Include if Non-Network Benefits are sold and if use of a Designated Facility is required in order to receive Network Benefits.* **[Pre-service Notification Requirement]** [For Designated Network Benefits you must notify us as soon as the possibility of a Congenital Heart Disease (CHD) surgery arises. If you do not notify us and if, as a result, the CHD services are not performed at a Designated Network Facility, Designated Network Benefits will not be paid.] [[1]Non-Network Benefits will apply.]] *Include when notification is required.* *[1]Include applicable reduction in Benefits.* [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 [[1]50 - 95]% of Eligible Expenses].			
Include when Designated Network Benefits are available. [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.] *Include when CHD benefits are sold and when both Network and Non-Network Benefits are available.* [Network and Non-Network Benefits	***[Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 -	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

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?**
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 *Schedule of Benefits*.]	1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]		
Include when use of a Designated Facility is required in order to receive Network Benefits. [For Network Benefits, CHD surgeries must be received at a Designated Facility. 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. 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 *Schedule of Benefits*.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]
Include when Network and Non-Network Benefits are limited and insert the limit selected by the group. [Network and Non-Network Benefits are limited to $[30,000 - 250,000] per CHD surgery.] *Include when Non-Network Benefits are limited and insert the limit selected by the group.* [Non-Network Benefits are limited to	***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

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?**
$[30,000 - 250,000] per CHD surgery.]	Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]		
Include for groups that purchase benefits for accident-related dental services. **[5.] [Dental Services - Accident Only]**			
Include when pre-service notification is required. *[1]Include applicable reduction in Benefits or no Benefits.* **[Pre-service Notification Requirement]** [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, [[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.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] ***[Non-Network]*** [Same as Network]	[Yes] [No] [Same as Network]	[Yes] [No] [Same as Network]
[6.] Diabetes 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?

[1]Include when the durable medical equipment benefit is sold.

[2]Include when the durable medical equipment benefit is not sold.

[3]Include when notification applies only to equipment that exceeds a minimum dollar amount and insert applicable dollar amount.

[4]Include applicable reduction in Benefits or no Benefits.

Pre-service Notification Requirement

For Non-Network Benefits you must notify us before obtaining any [[1]Durable Medical Equipment] [[2]diabetes equipment] for the management and treatment of diabetes [[3]that 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, [[4]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[4]you will be responsible for paying all charges and no Benefits will be paid].

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	***Network*** 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 *Schedule of Benefits*. ***Non-Network*** 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 *Schedule of Benefits*.
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment*. *Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.* [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-	***Network*** *[1]Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.* [[1]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*.] *[2]Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold.* *[3]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[4]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[2]For diabetes equipment, Benefits will be the same as those

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].]	stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [[3]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[4]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[5]Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold.* *[6]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[7]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[5]For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [[6]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[7]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[8]Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold.* *[9]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[10]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[8]For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [[9]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[10]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] ***Non-Network*** *[1]Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.* [[1]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*.] *[2]Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold.* *[3]Include when sold with a plan that has an annual deductible*		

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?**
	and select either "are" or "are not." *[4]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[2]For diabetes equipment, Benefits will be the same as those stated under *Durable Medical Equipment*. For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [[3]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[4]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] *[5]Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold.* *[6]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[7]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[5]For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [[6]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[7]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.] Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drug Rider*.] *[8]Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold.* *[9]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[10]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [[8]For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [[9]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[10]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		

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?**
Include for groups that purchase benefits for DME. **[7.] [Durable Medical Equipment]**			
[1]Include when notification applies only to DME that exceeds 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 any Durable Medical Equipment [[1]that 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, [[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].]			
Include the limit selected by the group. *[1]Include either option as standard plan design.* [[1]Limited to $[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].] [[1]Limited per year as follows: • [$[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.] 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].] *[1]Include when Benefits are provided for speech aid and tracheo-*	***[Network]*** [[50 - 100]%]	[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?**
esophageal voice devices. *[2]Include when devices are not included in the annual DME limit.* [[1]Benefits 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 [[2]not] included in the annual limits stated above.] *Always include when the DME benefit is sold.* [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.]	***[Non-Network]*** [[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?**
Include when benefit is limited. [Limited to $[100 - 5,000] per year.] **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. *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.)* [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: • [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.] • [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and*	***Network*** [[50 - 100]%] *Include bracketed provision and select either #1 or #2 if the Copayment is waived.* *[1]Include as standard; [2]Include only to match prior benefit plans.* [100% after you pay a Copayment of $[5 - 500] per visit. [If you are admitted as an inpatient to a Network Hospital [[1]directly from the Emergency room] [[2]within 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.]] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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] *Include for 2-tiered Copayment option.*	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
Nuclear Medicine - Outpatient.] • [Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.] • [Outpatient surgery procedures described under *Surgery - Outpatient*.] • [Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.] *[1]Include bracketed reference to Manipulative treatment when Manipulative treatment benefits are sold.* • [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [*[1]and *Manipulative Treatment]*.]]	[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] *Include for 3-tiered Copayment option.* [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] *Include for 4-tiered Copayment option.* [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]		

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?**
	Include if plan design includes retrospective review of emergency services. [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] ***Non-Network*** Same as Network	Same as Network	Same as Network
Include as standard only for groups of 15+. **[9.] [Hearing Aids]**			
Include the limit selected by the group. *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.* [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].]	***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[10.] Home Health Care			

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?**
Include if pre-service notification is required. *[1]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [For Non-Network Benefits 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.]			
Include the limit selected by the group. [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.] [Network Benefits are limited to [40 - 200] visits per year and Non-Network Benefits are limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.] *Include when infusion administration only is not included in the limit.* [This visit limit does not include any service which is billed only for the administration of intravenous infusion.]	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 50] per visit]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[11.] Hospice Care			

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?**
Include if pre-service notification is required. *[1]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [In addition, for Non-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]			
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per day] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per day]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[12.] Hospital - Inpatient Stay			

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?
Include when Benefit Activation Program is sold. *[1]Include applicable Benefit level.* **[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 [[1]50 - 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 *Customer Care* at the telephone number on your ID card.] *[1]Include applicable Benefit level.* **Pre-service Notification Requirement** 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 [[1]50 - 95]% of Eligible Expenses. *Include if pre-admission notification is required.* [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).]			
[1]Include heading and row when Designated Network Benefits apply. *Include when enhanced benefits apply to specific inpatient services.* *[2]Include when Physician's fees are paid under the facility charge.* [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:] • [The Copayment you pay for the facility charge [[2]and 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	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

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?**
the facility charge [[2]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].] [You can determine the specific surgical procedures or diagnoses 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.]	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 10,000] per Inpatient Stay] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied] [Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

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]		
Include for groups that purchase infertility benefits. **[13]. [Infertility Services]**			
When this benefit is purchased, pre-service notification will always be required. [1]Include applicable reduction in Benefits or no Benefits. **[Pre-service Notification Requirement]** [You must notify us as soon as the possibility of the need for Infertility Services arises. If you fail to notify us as required, [[1]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[1]you will be responsible for paying all charges and no Benefits will be paid].]			
[1]Include heading and row when Designated Network Benefits apply.	***[[1]Designated Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
Include the limit selected by the group. *[1]Include when the maximum benefit is combined with infertility drugs under the RX rider.* [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. [[1]This limit includes Benefits for infertility medications provided under the *Outpatient Prescription Drug Rider*.] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.]	***[Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Non-Network] [[50 - 100]%] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]

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			
Include when pre-service notification is required for sleep studies. *[1]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.]			
[1]Include heading and row when Designated Network Benefits apply. *Include limit selected by group.* [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 $[5 - 100] per service]	[Yes] [No]	[Yes] [No]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per service]	[Yes] [No]	[Yes] [No]
	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			

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?**
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 [[1]50 - 95]% of Eligible Expenses.]			
[1]Include heading and row when Designated Network Benefits apply. *Include limit selected by group.* [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]	[Yes] [No]	[Yes] [No]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[25 - 500] per service]	[Yes] [No]	[Yes] [No]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[25 - 500] per service]	[Yes] [No]	[Yes] [No]
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].]			
***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.* *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."*	***[Network]*** *[Inpatient/Intermediate]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No]
Select from these limit options when limits apply only to Mental Health Services described in this section. [Inpatient/Intermediate *Mental Health Services* are limited to [10 - 100] days per year.] [Outpatient *Mental Health Services* are limited to [10 - 100] visits per year.] [Non-Network Benefits for Inpatient/Intermediate *Mental Health Services* are limited to [10 - 100] days per year.] [Non-Network Benefits for outpatient *Mental Health Services* are limited to [10 - 100] visits per year.]	*[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] ***[Non-Network]*** *[Inpatient/Intermediate]*	[Yes] [No] [Yes] [No]	[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?**
Select from these limit options when limits apply to Mental Health Services described in this section combined with Neurobiological Disorders - Autism Spectrum Disorders below. [Benefits for any combination of *Mental Health Services* described in this section and *Neurobiological Disorders - Autism Spectrum Disorders* described below are limited as follows: • [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*.]	[[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]		
Select from these limit options when limits apply to Mental Health Services described in this section combined with Substance Use Disorder Services below. [Benefits for any combination of *Mental Health Services* described in this section and *Substance Use Disorder Services* described below are limited as follows: • [10 - 100] days per year for Inpatient/Intermediate *Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Mental Health Services* and *Substance Use Disorder Services*.]	*[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]	[Yes] [No]	[Yes] [No]
Note: *When parity applies, these benefit statements must be used in lieu of those options available above to*	***[Network]*** [Depending upon where the Covered Health Service is		

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?**
assure that cost sharing will always be equal to medical services.	provided, Benefits for outpatient *Mental Health Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate *Mental Health Services* will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
	[Non-Network] [Depending upon where the Covered Health Service is provided, Benefits for outpatient *Mental Health Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate *Mental Health Services* will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
Include for groups that purchase mental health benefits. . **[17.] [Neurobiological Disorders - Autism Spectrum Disorder Services]**			
When this benefit is purchased, prior authorization will always be required. [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*	***[Network]*** *[Inpatient/Intermediate]*	[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?**
business (50 and fewer) or for non-ERISA groups that choose to be exempt from Parity requirements. Include the limit selected by the group. *When parity does not apply, this first set of separate benefit statements and limits can be used. When parity does apply, delete these benefit and limit statements and use the "Depending upon" provisions further below."*	[[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]		
Select from these limit options when limits apply only to Neurobiological Disorders - Autism Spectrum Disorders described in this section. [Inpatient/Intermediate *Neurobiological Disorders -Autism Spectrum Disorders* are limited to [10 - 100] days per year.] [Outpatient *Neurobiological Disorders - Autism Spectrum Disorders* are limited to [10 - 100] visits per year.] [Non-Network Benefits for Inpatient/Intermediate *Neurobiological Disorders -Autism Spectrum Disorders* are limited to [10 - 100] days per year.] [Non-Network Benefits for outpatient *Neurobiological Disorders -Autism Spectrum Disorders* are limited to [10 - 100] visits per year.] *Select from these limit options when limits apply to Neurobiological Disorders - Autism Spectrum Disorders described in this section combined with Mental Health Services above.* [Benefits for any combination of *Neurobiological Disorders - Autism*	*[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] ***[Non-Network]*** *[Inpatient/Intermediate]* [[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	[Yes] [No] [Yes] [No]	[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?**
Spectrum Disorders described in this section and *Mental Health Services* described above are limited as follows: • [10 - 100] days per year for Inpatient/Intermediate *Neurobiological Disorders - Autism Spectrum Disorders* and *Mental Health Services*. • [10 - 100] visits per year for outpatient *Neurobiological Disorders - Autism Spectrum Disorders* and *Mental Health Services*.]	Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]		
	[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]	[Yes] [No]	[Yes] [No]
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.*	***[Network]*** [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*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
	[Non-Network]		

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 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*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
Include for groups that purchase benefits for obesity surgery. **[18.] [Obesity Surgery]**			
When this benefit is purchased, pre-service notification will always be required. [1]Include applicable Benefit level. **[Pre-service Notification Requirement]** [You must notify us [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to notify us as required, Benefits will be reduced to [[1]50 - 95]% of Eligible Expenses.] *Include if pre-admission notification is required.* [In addition, for Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.] **[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]**			
[1]Include heading and row when Designated Network Benefits apply. *[2]Include when Designated Network Benefits apply.* *[3]Include when Network Benefits are available.* *[4]Insert the limit selected by the group.* [Any combination of [[2]Designated Network Benefits] [[3], Network Benefits] and Non-Network Benefits is limited to $[[4]50,000 - 250,000] during the entire	***[[1]Designated Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		

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?**
period of time a Covered Person is enrolled for coverage under the Policy. Non-Network Benefits are further limited to $[[4]5,000 - 30,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.] *Include when there is not a Network level of benefits available.* [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.]	***[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 *Schedule of Benefits*.] ***[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 *Schedule of Benefits*.]		
Include if group purchases benefits for ostomy supplies. **[19.] [Ostomy Supplies]**			
Include the limit selected by the group. [Limited to $[500 - 25,000] per year.]	***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[20.] Pharmaceutical Products - 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?**
Include when notification is required for IV infusions. *[1]Include applicable reduction in Benefits.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.] *Include when notification is required for select Pharmaceutical Products.* [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 [[1]50 - 95]% of Eligible Expenses. 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.]			
[1]Include heading and row when Designated Network Benefits apply. *Include limit selected by group.* [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 $[5 - 100] per Pharmaceutical Product] *Include when Coinsurance is tiered and select the appropriate number of tiers by plan design.* [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]	[Yes] [No] [Yes, except when provided during a Physician office visit]	[Yes] [No] [Yes, except when provided during a Physician office visit]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per	[Yes] [No] [Yes, except when provided during a	[Yes] [No] [Yes, except when provided during a Physician office

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?**
	Pharmaceutical Product] *Include when Coinsurance is tiered and select the appropriate number of tiers by plan design.* [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per Pharmaceutical Product] *Include when Coinsurance is tiered and select the appropriate number of tiers by plan design.* [[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]	Physician office visit] [Yes] [No] [Yes, except when provided during a Physician office visit]	visit] [Yes] [No] [Yes, except when provided during a Physician office visit]
[21.] Physician Fees for Surgical and Medical 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?**
Include when Benefit Activation Program is sold. *[1]Include applicable Benefit level.* **[Benefit Activation Notification Requirement]** [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 [[1]50 - 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 *Customer Care* at the telephone number on your ID card.]			
[1]Include heading and row when Designated Network Benefits apply. *Include when enhanced benefits apply to specific Physician services.* [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:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.]	***[[1]Designated Network]*** [[50 - 100]%]	[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?**
• [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] **[Enhanced Benefits:]** • [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].] [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.]			
[2]Include text if the plan design supports paying non-network benefits for a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist). [[2]Covered 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.] *[3]Include text if the plan design supports paying non-network benefits for a non-Network consulting Physician, assistant surgeon or surgical assistant.* [[3]Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical	***Network*** [50 - 100]%	[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?**
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.]	***Non-Network*** [50 - 100]%	[Yes] [No]	[Yes] [No]
[22.] Physician's Office Services - Sickness and Injury			

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?**
Include when Benefit Activation Program is sold. *[1]Include applicable Benefit level.* **[Benefit Activation Notification Requirement]** [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 [[1]50 - 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 *Customer Care* at the telephone number on your ID card.]			
Include if group chooses to limit benefit. [1]Insert limit selected by group. [Limited to [[1]2 - 10] visits per year.] *[1]Include heading and row when Designated Network Benefits apply.* *Include when enhanced benefits apply to specific physician office services.* [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:] **[Specialties:]** • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.]	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [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] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
• [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] **[Enhanced Benefits:]** • [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].] [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.]	that year] [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] [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]		
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	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
subject to Coinsurance only.) [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: • [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.] • [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*.] • [Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.] • [Outpatient surgery procedures described under *Surgery - Outpatient*.] • [Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.] *[1]Include bracketed reference to Manipulative treatment when Manipulative treatment benefits are sold.* • [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment].*]]	per visit for a Primary Physician office visit or $[5 - 100] per visit for a Specialist Physician office visit] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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] [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] ***Non-Network***		

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]%] [100% after you pay a Copayment of $[5 - 100] per visit] [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] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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] [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	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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]		
[1]Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude. [2]If Maternity Services are excluded, Complications of Pregnancy must always be included. **[23.] Pregnancy - [[1]Maternity Services] [[2]Complications of Pregnancy only]**			

[1]Include when benefits are provided for maternity services. [2]Include applicable Benefit level.

[[1]Pre-service Notification Requirement]

[[1]For 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 [[2]50 - 95]% of Eligible Expenses.]

[3]Include when benefits are provided for complications of pregnancy only. [4]Include applicable Benefit level.

[[3]Pre-service Notification Requirement]

[[3]For 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 [[4]50 - 95]% of Eligible Expenses.]

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.

[1]Include when benefits are provided for maternity services.

[[1]Network]

[3]Include when an annual deductible applies to network benefits.

[4]Include when Network services in the Physician's office are subject to a Copayment.

[[1]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* [[3]except 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

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?**
	length of stay]. [[4]For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.] ***[[1]Non-Network]*** *[3]Include when an annual deductible applies to non-network benefits.* *[4]Include when Non-Network services in the Physician's office are subject to a Copayment.* [[1]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* [[3]except 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]. [[4]For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.] *[2]Include when benefits are provided for complications of pregnancy only.* ***[[2]Network]*** [[2]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[[2]Non-Network]*** [[2]Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.]		
[24.] Preventive Care Services			
Include when preventive care is limited and select the limit that applies. [Preventive care services are limited to $[100 - 1,000] per year.] **Physician office services** 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,	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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] [100% after you pay a	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
16 years, and 18 years. No Copayment, Coinsurance or deductible will be applicable to Network or non-Network children's immunizations.	Copayment of $[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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] [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] [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available.]
Lab, X-ray or other preventive tests:	***Network*** [[50 - 100]%] [100% after you pay a	[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?**
	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.]
Include when group purchases benefits for prosthetic devices. Prosthetics are a mandated benefit in Arkansas. **[25.] Prosthetic Devices and Services**			
Include if notification is required. *[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 [[1]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.			
Include if pre-admission notification is required.			
[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).]			
	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 *Schedule of Benefits*. *Include when group does not purchase benefits for prosthetic devices.* *[1]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[2]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [[1]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[2]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]] ***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 *Schedule of Benefits*. *Include when group does not purchase benefits for prosthetic devices. The Benefit level inserted here must be the same as the plan Coinsurance level.* *[1]Include when sold with a plan that has an annual deductible and select either "are" or "are not."* *[2]Include when sold with a plan that has an out-of-pocket maximum and select either "applies" or "does not apply."* [For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [[1]and Benefits [are] [are not] subject to payment of the Annual Deductible]. [[2]Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]		
Include entire section when			

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?**
rehabilitation services benefit is sold. *[1]Include when Manipulative Treatment benefits are sold.* **[27.] [Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment]]**			
Include when notification is required for any rehabilitation service. *[1]Include applicable Benefit level.* **[Pre-service Notification Requirement]** [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 [[1]50 - 95]% of Eligible Expenses.]			
Include when per therapy limits apply. *[1]Include when Manipulative Treatment benefits are sold.* *[2]Include when vision therapy benefits are sold.* [Limited per year as follows: • [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	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
therapy.]] *Include when combined therapy visit limits apply.* *[1]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.* *[2]Include when vision therapy benefits are sold.* [Any combination of physical therapy, occupational therapy, [[1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [[2]and vision therapy] is limited to [10 - 160] visits per year.] *Include when combined therapy dollar limits apply.* *[1]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.* *[2]Include when vision therapy benefits are sold.* [Any combination of physical therapy, occupational therapy, [[1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [[2]and vision therapy] is limited to $[750 - 12,000] per year.] *Include when combined therapy visit limits apply separately to network benefits and to non-network benefits.*	***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [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]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
[1]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. *[2]Include when vision therapy benefits are sold.* [Network Benefits for any combination of physical therapy, occupational therapy, [1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [2]and vision therapy] are limited to [10 - 160] visits per year.] [Non-Network Benefits for any combination of physical therapy, occupational therapy, [1]Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, [2]and vision therapy] are limited to [10 - 160] visits per year.]			
[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
Include when notification is required for scopic procedures. *[1]Include applicable Benefit level.* **[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 [1]50 - 95]% of Eligible Expenses.]			
[1]Include heading and row when Designated Network Benefits apply.	***[[1]Designated Network]*** [[50 - 100]%] ***Network***	[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?**
	[50 - 100]% ***Non-Network*** [50 - 100]%	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
[1]Include applicable Benefit level.			
Pre-service Notification Requirement 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 [[1]50 - 95]% of Eligible Expenses. *Include if pre-admission notification is required.* [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).]			
Include limit selected by group. [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.]	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] *Copayment option below identified as #1 to be tied only to either of the options #1 below with an Inpatient Stay maximum.* [[1]100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [[1]100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 5,000] per Inpatient Stay] *Variable #1 can be*	[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?**
	used only with options numbered #1 above. [[1]If 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.] [No Copayment applies if you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility.] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[50 - 1,000] per day] [100% after you pay a Copayment of $[50 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[50 - 1,000] per day to a maximum Copayment of $[50 - 10,000] per Inpatient Stay]	[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?**
Include for groups that purchase substance use disorder benefits. **[30.] [Substance Use Disorder Services]**			
When this benefit is purchased, prior authorization will always be required. [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 exempt from Parity requirements. Include the limit selected by the group.* *When parity does not apply, this first set of separate benefit statements and limits can be used. When parity does apply, delete these benefit and limit statements and use the "Depending upon" provisions further below."*	***[Network]*** *[Inpatient/Intermediate]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No]
Select from these limit options when limits apply only to Substance Use Disorder Services described in this section. [Inpatient/Intermediate *Substance Use Disorder Services* are limited to [10 - 100] days per year.] [Outpatient *Substance Use Disorder Services* are limited to [10 - 100] visits	*[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	[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?**
per year.] [Non-Network Benefits for Inpatient/Intermediate *Substance Use Disorder Services* are limited to [10 - 100] days per year.] [Non-Network Benefits for outpatient *Substance Use Disorder Services* are limited to [10 - 100] visits per year.] *Select from these limit options when limits apply to Substance Use Disorder Services described in this section combined with Mental Health Services above.* [Benefits for any combination of *Substance Use Disorder Services* described in this section and *Mental Health Services* described above are limited as follows: • [10 - 100] days per year for Inpatient/Intermediate *Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Mental Health Services* and *Substance Use Disorder Services*.]	- 75] per group visit.] [100% for visits for medication management]		
	[Non-Network] *[Inpatient/Intermediate]* [[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	[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?**
	of $[100 - 5,000] per Inpatient Stay]		
	[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]	[Yes] [No]	[Yes] [No]
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.*	***[Network]*** [Depending upon where the Covered Health Service is provided, Benefits for outpatient *Substance Use Disorder Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate *Substance Use Disorder Services* will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		
	[Non-Network] [Depending upon where the Covered Health Service is provided, Benefits for outpatient *Substance Use Disorder Services* will be the same as those stated under *Physician's Office Services - Sickness and Injury,* and Benefits for inpatient/intermediate *Substance Use Disorder* Services will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] *Include when outpatient visits for medication management are paid at 100%.* [Benefits for outpatient visits for medication management will be paid at 100%.]		

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?
[31.] Surgery - Outpatient			

Include when Benefit Activation Program is sold.

[1]Include applicable Benefit level.

[Benefit Activation Notification Requirement]

[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 [[1]50 - 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 *Customer Care* at the telephone number on your ID card.]

Include when notification is required.

[1]Include applicable Benefit level.

[Pre-service Notification Requirement]

[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.]

[1]Include heading and row when Designated Network Benefits apply. *Include provision below when enhanced benefits apply to specific outpatient surgical services.* *[2]Include when Physician's fees are paid under the facility charge.* [When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as follows:] • [The Copayment you pay for the facility charge [[2]and 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	***[[1]Designated Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[10 - 1,000] per date of service] [100%after you pay a Copayment of $[10 - 1,000] per date of service, to a maximum Copayment of $[10 - 5,000] per year]]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

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?**
the facility charge [[2]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].] [You can determine the specific surgical procedures 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.]			
	Network		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[[100% after you pay a Copayment of $[10 - 1,000] per date of service]		[Yes, after the Per Occurrence Deductible is satisfied]
	[100% after you pay a Copayment of $[10 - 1,000] per date of service, to a maximum Copayment of $[10 - 5,000] per year]]		
	Non-Network		
	[[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of $[10 - 1,000] per date of service]		[Yes, after the Per Occurrence Deductible is satisfied]
	[100% after you pay a Copayment of $[10 - 1,000] per date of service, to a maximum Copayment of $[10 - 5,000] per year]]		

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?
Include when group purchases TMJ benefit. This is a mandated benefit in Arkansas. **[32.] [Temporomandibular Joint Services]**			

When this benefit is purchased, pre-service notification will always be required.

[1]Include applicable Benefit level.

[Pre-service Notification Requirement]

[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 [[1]50 - 95]% of Eligible Expenses.]

Include if pre-admission notification is required.

[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions.]

Include the limit selected by the group. [Limited to $[1,000 - 20,000] per year.]	***[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 *Schedule of Benefits*.] ***[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 *Schedule of Benefits*.]		
[33.] Therapeutic Treatments - Outpatient			

Include when notification is required.

[1]Include applicable Benefit level.

[Pre-service Notification Requirement]

[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 [[1]50 - 95]% of Eligible Expenses.]

[1]Include heading and row when Designated Network Benefits apply.	***[[1]Designated Network]***		

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]%] [100% after you pay a Copayment of $[25 - 100] per treatment]	[Yes] [No]	[Yes] [No]
	Network [[50 - 100]%] [100% after you pay a Copayment of $[25 - 100] per treatment]	[Yes] [No]	[Yes] [No]
	Non-Network [[50 - 100]%] [100% after you pay a Copayment of $[25 - 100] per treatment]	[Yes] [No]	[Yes] [No]
[34.] Transplantation Services			

[1]Include if Non-Network Benefits are sold.

Pre-service Notification Requirement

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 result, the services are not performed at a Designated Facility, Network Benefits will not be paid. [[1]Non-Network Benefits will apply.]

[2]Include applicable benefit reduction penalty.

[[1]For Non-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 fail to notify us as required, Benefits will be reduced to [[2]50 - 95]% of Eligible Expenses.]

Include if Non-Network Benefits are sold and pre-admission notification is required.

[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).]

For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits. *Include when Non-Network Benefits*	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied]

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?**
are limited and insert the limit selected by the group. [Non-Network Benefits are limited to $[30,000 - 250,000] per transplant.]	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] ***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Yes, after the Per Occurrence Deductible is satisfied] [Non-Network Benefits are not 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?**
Include when urgent care services are limited and insert the limit selected by the group. [Limited to $[100 - 5,000] per year.] [Limited to [2 - 10] visits per year.] *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.)* [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: • [Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.] • [Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient*.] • [Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.] • [Outpatient surgery procedures described under *Surgery - Outpatient*.] • [Outpatient therapeutic procedures described under *Therapeutic Treatments -*	***Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]

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?**
Outpatient.] *[1]Include bracketed reference to Manipulative treatment when Manipulative treatment benefits are sold.* • [Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy [[1]*and *Manipulative Treatment]*.]]	***Non-Network*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 150] per visit] [100% after you pay a Copayment of $[5 - 150] per visit to a maximum Copayment of $[5 - 5,000] per year] [100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year] [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]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]
Include when group purchases benefits for vision exams. **[36.] [Vision Examinations]**			
[Limited to [1 exam] [[2-3] exams] per year.] [Limited to [1 exam] [[2-3] exams]	***[Network]*** [[50 - 100]%]	[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?**
every [2 - 3] years.]	[100% after you pay a Copayment of [$5 - 75] per visit] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of [$5 - 75] per visit] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]
Include when group purchases benefits for wigs. **[37.] [Wigs]**			
Include the limit selected by the group. [Limited to $[100 - 1,000] per year.] [Limited to $[100 - 5,000] every [24 - 36] months.]	***[Network]*** [[50 - 100]%] ***[Non-Network]*** [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
Additional Benefits Required By Arkansas Law			
[38.] Dental Services - Anesthesia and Hospitalization			
Pre-service Notification Requirement Any applicable notification requirements will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.			
[1]Include heading and row when Designated Network Benefits apply.	***[[1]Designated Network]*** [Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*.] ***Network*** Benefits will be the same as those stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits*. ***Non-Network***		

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 *Hospital - Inpatient Stay* in this *Schedule of Benefits*.		
[39.] In Vitro Fertilization Services			
[1]*Include applicable reduction in Benefits or no Benefits.*			
Pre-service Notification Requirement			
You must notify us as soon as the possibility of the need for in vitro fertilization arises. If you fail to notify us as required, [[1]Benefits will be reduced to [50 - 95]% of Eligible Expenses] [[1]you will be responsible for paying all charges and no Benefits will be paid].			
1Include heading and row when Designated Network Benefits apply Limited to a lifetime maximum of $15,000.	[[1]***Designated Network***] [50 - 100%] ***Network*** [50 - 100%] ***Non-Network*** [[50 - 100]%] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Yes] [No] [Yes] [No] [Non-Network Benefits are not available.]
[40.] Medical Foods			
	[1]*Include when group purchases the Outpatient Prescription Drug Rider.* ***Network*** Depending upon where the Covered Health Service is provided, Benefits will be [50 - 100]% [[1]or as provided under the *Outpatient Prescription Drug Rider*]. ***Non-Network*** Same as Network	[Yes] [No] Same as Network	[Yes] [No] Same as Network

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?**
Include ONLY when group purchases plan with MH full parity. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. **[[41.] Mental Health Services - Inpatient and Intermediate]**			
When this benefit is purchased, prior authorization will always be required. *[1]Include applicable reduction in benefits.* **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, Benefits will be reduced to [[1]50-95]% of Eligible Expenses.			
	[*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 *Schedule of Benefits*.**]** **[*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 *Schedule of Benefits*.**]**		
Include ONLY when group purchases plan with MH full parity. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing. **[[42.] Mental Health Services - Outpatient]**			
Include authorization language only for groups that elect the "Employer Coverage" option. Delete authorization language for groups that elect the "National Service Center" option. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
[1]Include heading and row when Designated Network Benefits apply.	***[[1]Designated Network]***	[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?**
	[50 - 100%] **[*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 *Schedule of Benefits*.**]** **[*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 *Schedule of Benefits*.**]**		
Mandated offer in Arkansas. **[[43.] Musculoskeletal Disorders of the Face, Neck or Head]**			
[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 *Schedule of Benefits*.]			
[1]Include heading and row when Designated Network Benefits apply [Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*.] [Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*.] [Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits*.]	***[[1]Designated Network]*** [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.] ***[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 *Schedule of Benefits*.] ***[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 *Schedule of Benefits*.]		
Include ONLY when group purchases plan with inpatient/intermediate 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			

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?**
writing. **[[44.] Substance Abuse Services - Inpatient and Intermediate]**			
When this benefit is purchased, prior authorization will always be required. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
Include the limit selected by the group. [Limited to [10 - 100] days per year.] [Non-Network Benefits are limited to [10 - 100] days per year.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per	[Yes] [No] [Yes] [No]	[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?**
	Inpatient Stay]		
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. **[[45.] Substance Abuse Services - Outpatient]**			
Include authorization language only for groups that elect the "Employer Coverage" option. Delete authorization language for groups that elect the "National Service Center" option. **[Prior Authorization Requirement]** [You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.]			
Include the limit selected by the group. [Limited to [10 - 100] visits per year.] [Non-Network Benefits are limited to [10 - 100] visits per year.]	***[Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit] ***[Non-Network]*** [[50 - 100]%] [100% after you pay a Copayment of $[5 - 75] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[[46.] Orthotic Devices and Services			
Include if notification is required. *[1]Include when notification applies only to prosthetics that exceed a minimum dollar amount and insert*			

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?**
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 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

[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 [[1]Designated 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, [[1]Mental Illness,] [[2]mental 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 [[1]Designated Network Benefits and] Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a [[1]Designated 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.

  - **[**[1]For 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.

  - **[**[2]Fee(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.

Certificate of Coverage

UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy

This Certificate of Coverage (Certificate) is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this *Certificate* the Policy includes:

- The *Group Policy*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document

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

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

Other Information You Should Have

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

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

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of Arkansas. The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of Arkansas are the laws that govern the Policy.

Introduction to Your Certificate

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

How to Use this Document

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

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 8: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

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

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

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

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*. You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

Don't Hesitate to Contact Us

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

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

Arkansas Insurance Department

[Consumer Services Division]

[1200 West Third Street]

[Little Rock, AR 72201-1904]

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

Your Responsibilities

Be Enrolled and Pay Required Contributions

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

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as a Subscriber or his or her Dependent as those terms are defined in *Section 9: Defined Terms*.

Your Enrolling Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy and receive Benefits. If you have questions about this, contact your Enrolling Group.

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

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

Decide What Services You Should Receive

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

Choose Your Physician

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

Pay Your Share

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

Pay the Cost of Excluded Services

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

Show Your ID Card

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

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

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

We have the discretion to do the following:

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

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

Pay for Our Portion of the Cost of Covered Health Services

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

Pay Network Providers

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

Pay for Covered Health Services Provided by Non-Network Providers

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

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

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

Offer Health Education Services to You

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

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Section 1: Covered Health Services

Benefits for Covered Health Services

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

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

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

[1]*Include when a Per Occurrence Deductible applies.*

- The amount you must pay for these Covered Health Services (including any Annual Deductible, [Per Occurrence Deductible,] Copayment and/or Coinsurance).

[1]*Include when an Annual Maximum Benefit applies.*

- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services[[1], any Annual Maximum Benefit,] and/or any Maximum Policy Benefit).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for notifying us or obtaining prior authorization.

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

Include when group purchases benefits for acupuncture services.

[1.] [Acupuncture Services]

[Acupuncture services for the following conditions:

- Pain therapy.
- Nausea that is related to surgery, Pregnancy or chemotherapy.

Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.
- Acupuncturist.]

[2.] Ambulance Services

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

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

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

Include when group purchases benefits for clinical trials.

[3.] [Clinical Trials]

[Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer.
- Cardiovascular disease (cardiac/stroke).
- Surgical musculoskeletal disorders of the spine, hip, and knees.

Include to support expanding clinical trial benefit to other diseases or disorders.

- [Other diseases or disorders for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.]

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be a qualifying clinical trial, a clinical trial must meet all of the following criteria:

- Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.

- *Agency for Healthcare Research and Quality (AHRQ)*.
- *Centers for Medicare and Medicaid Services (CMS)*.
- *Department of Defense (DOD)*.
- *Veterans Administration (VA)*.

- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.]

Include when group purchases CHD benefit.

[4.] [Congenital Heart Disease Surgeries]

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

Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

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

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

Include when group purchases accidental dental benefit.

[5.] [Dental Services - Accident Only]

[Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.

- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.]

[6.] Diabetes Services

Diabetes Self-Management Training is mandated in Arkansas.

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

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

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

Diabetic Self-Management Items

Include paragraph below when group purchases the drug rider.

[1]Include only when group purchases benefits for durable medical equipment.

[Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. [[1]An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment*.] Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider*.]

Include paragraph and bulleted list below when group does not purchase the drug rider.

[1]Include only when group does not purchase benefits for durable medical equipment.

[2]Include only when group purchases benefits for durable medical equipment.

[Insulin pumps [[1]that are not fully implanted into the body,] and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including, but not limited to:

- [[2]Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment*.]
- Blood glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.]

Include when group purchases durable medical equipment benefit.

[7.] [Durable Medical Equipment]

[Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.

- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

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

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

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

Include when benefits for speech aid devices and tracheo-esophageal voice devices are sold.

[Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.]

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

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

Benefits are available for repairs and replacement, except that:

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

Include when DME Benefit is tiered and tiers are not to be included in COC.

[To determine the Tiers to which Durable Medical Equipment are assigned, contact [www.myuhc.com] or *Customer Care* at the telephone number on your ID card.]

Include when DME Benefit is tiered and tiers are to be included in COC.

[Durable Medical Equipment in Tier 1 is any item not specifically outlined in Tiers 2 or 3 below.

Durable Medical Equipment in Tier 2 is limited to the items listed below and any necessary supplies:

- Oxygen.
- Tube feeding pumps.
- Negative pressure wound therapy pumps.
- Bi-level Positive Airway Pressure machines (BiPAPs).
- Bone growth stimulators.
- Pulse oximeters.
- Wearable automatic external defibrillators.
- Insulin pumps.
- Neuromuscular stimulators that we determine to be proven for use, and which are used as part of an approved rehabilitative program.

Include when benefits for speech aid devices and tracheo-esophageal voice devices are sold.

- [Speech aid devices and tracheo-esophageal voice devices.]

Durable Medical Equipment in Tier 3 is limited to the items listed below and any necessary supplies:

- Power wheel chairs.
- Ventilators.
- High frequency chest compression devices.
- Specialty beds for pressure reduction.]]

[8.] Emergency Health Services - Outpatient

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

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

Include if plan design includes retrospective review of emergency services.

[Benefits under this section are not available for services to treat a condition that does not meet the

Include as standard only for groups of 15+.

[9.] [Hearing Aids]

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

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

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

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.

- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.]

[10.] Home Health Care

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

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

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

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

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

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

[11.] Hospice Care

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

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

[12.] Hospital - Inpatient Stay

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

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

[1]Include if RAPLs and consulting physicians are paid under the facility charge.

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

[2]Include if RAPLs and consulting physicians are paid under the Physician fee category.

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

Include when group purchases benefits for infertility services.

[13.] [Infertility Services]

[Services for the treatment of infertility when provided by or under the direction of a Physician, limited to the following procedures:

- Ovulation induction.
- Insemination procedures (Artificial Insemination (AI) and IntraUterine Insemination (IUI)).
- Assisted Reproductive Technologies (ART).
- Pre-implantation Genetic Diagnosis (PGD) for diagnosis of genetic disorders only.
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

To be eligible for Benefits, the Covered Person must meet all of the following:

- Have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35.
- Be under age 44, if female.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.]

[14.] Lab, X-Ray and Diagnostics - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office.

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office] include, but are not limited to:

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

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

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

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design supports paying the physician's office services benefit for Lab/X-ray performed in a physician's office.

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

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

[15.] Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

[1]Include when plan design has an office visit copayment and supports paying CT, PET, MRI, MRA and nuclear medicine benefit for services performed in a physician's office.

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

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

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design supports paying the physician's office services benefit for major diagnostics performed in a physician's office.

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

Include when group purchases plan with 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]

[Mental Health Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits for Mental Health Services include:

- Mental health evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Inpatient.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Individual, family and group therapeutic services.
- Crisis intervention.

[1]For groups not subject to Federal Parity requirements, include benefit conversion information if the group purchases option to convert inpatient days to intermediate care or transitional care. Delete for groups subject to Federal Parity requirements.

The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. [[1]When limits apply to inpatient or Intermediate Care services in the *Schedule of Benefits*, inpatient days may be converted to Intermediate Care (such as Partial Hospitalization/Day Treatment or Intensive Outpatient Treatment programs) or Transitional Care at the discretion of the Mental Health/Substance Use Disorder Designee.

One inpatient day is equivalent to:

[2]Adjust days according to plan parameters (standard is two sessions of partial hospitalization/day treatment; five sessions of intensive outpatient treatment; six outpatient visits; ten days of Transitional Care.

- One day at a Residential Treatment Facility.
- [[2]Two] sessions of Partial Hospitalization/Day Treatment.
- [[2]Five] sessions of Intensive Outpatient Treatment.
- [[2]Six] outpatient visits.
- [[2]Ten] days of Transitional Care.]

Referrals to a Mental Health Services provider are at the discretion of the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating all of your care.

Mental Health Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for *Mental Health Services*.

Include when group purchases plan with inpatient/intermediate MH/SA 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

Special Mental Health Programs and Services

[1]Include for non-parity customers.

[2]Include for parity customers.

[3]Include if applicable.

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Mental Health Services Benefit. [[1]Depending on the type of programs or services available, the programs or services may be offered to you at no cost or as an exchange of Benefits. When offered as an exchange of Benefits for use of these programs or services, this exchange is based on the assignment of the program or service to either inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use and any associated Copayment, Coinsurance and deductible.] [[2]The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use.] Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care [[3]or through other pathways as described in the program introductions]. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.]

Include when group purchases plan with benefits for autism spectrum disorders. When Mental Health Benefits are included, core autism benefits will always be included because medical benefits for autism treatment are paid under the medical plan based on place of service (parity issue).

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

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

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

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available [[1]under the applicable medical Covered Health Services categories in this *Certificate*] [[2]as described under [autism benefit section name] below].

Benefits include:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Inpatient/24-hour supervisory care.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Individual, family, therapeutic group, and provider-based case management services.
- Psychotherapy, consultation, and training session for parents and paraprofessional and resource support to family.
- Crisis intervention.
- Transitional Care.

Include when expanded services for autism are sold.

[Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).]

Autism Spectrum Disorder services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for *Neurobiological Disorders - Autism Spectrum Disorder Services*.]

Include when group purchases benefits for obesity surgery.

[18.] [Obesity Surgery]

[1]Include when specific criteria apply to benefits for obesity surgery and when only the criterion for a BMI of greater than 40 applies.

[Surgical treatment of obesity when provided by or under the direction of a Physician [[1]when the Covered Person has a Body Mass Index (BMI) of greater than 40].

[2]Include when specific criteria apply to benefits for obesity surgery and when either criterion must be met.

[[2]Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met:]

- [[2]The Covered Person must have a Body Mass Index (BMI) of greater than 40.]
- [[2]The Covered Person must have a Body Mass Index (BMI) of greater than 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by, obesity.]]

Include when group purchases benefits for ostomy supplies.

[19.] [Ostomy Supplies]

[Benefits for ostomy supplies are limited to the following:

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

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

[1]Include when group purchases benefits for infertility services.

[20.] Pharmaceutical Products - Outpatient

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

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. [[1]Benefits under this section do not include medications for the treatment of infertility.]

Include only when benefits are tiered for Pharmaceutical Products.

[Pharmaceutical Products are assigned to various tiers. The *Prescription Drug List Management Committee* makes the final classification of a Pharmaceutical Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Pharmaceutical Product, as well as whether notification requirements should apply. Economic factors may include, but are not limited to, the Pharmaceutical Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Pharmaceutical Product.

NOTE: We may periodically change the placement of a Pharmaceutical Product among the tiers. These changes generally occur quarterly, but no more than six times per year. These changes may occur without prior notice to you. As a result of such changes, the tier status of a Pharmaceutical Product may change, and you may be required to pay more or less for that Pharmaceutical Product.

To determine the tiers to which Pharmaceutical Products are assigned, contact [www.myuhc.com] or *Customer Care* at the telephone number on your ID card. The amount that you are required to pay for Pharmaceutical Products will vary depending upon the tier to which the Pharmaceutical Product is assigned.]

Include when Step Therapy applies.

[Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical

Product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[21.] Physician Fees for Surgical and Medical Services

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

[22.] Physician's Office Services - Sickness and Injury

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

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

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

Benefits under this section include allergy injections.

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

[1]Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office. [2]Include when only minor diagnostics are included under Physician's Office Services, but major diagnostics in a Physician's office are paid under the major diagnostic category.

[[1]Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. [[2]Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services.]]

[3]Include when plan design supports paying Benefits for lab/X-ray only under the Lab/X-ray benefit.

[[3]When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.]

[1]Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude.

[2]If Maternity Services are excluded, Complications of Pregnancy must always be included.

[23.] Pregnancy - [[1]Maternity Services] [[2]Complications of Pregnancy only]

[1]Include #1 below when Benefits are available for full Maternity Services and delete option #2 further below.

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

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

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

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

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

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

[2]Include #2 below when Benefits are available only for Complications of Pregnancy and delete option #1 above.

[[2]Benefits for Complications of Pregnancy include all Covered Health Services required for the non-obstetrical treatment of a condition related to a Complication of Pregnancy during a Pregnancy or during the post-partum period.

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

We will pay Benefits for an Inpatient Stay of at least 96 hours for the mother and newborn child following a non-elective cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than this minimum time frame.]

[24.] Preventive Care Services

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

Physician office services:

- Routine physical examinations.
- Well baby and well child care.
- Immunizations.
- Hearing screening.

Lab, X-ray or other preventive tests:

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

Prosthetics is a mandated benefit in Arkansas.

[25.] Prosthetic Devices and Services

Benefits are available for the evaluation and treatment of a condition that requires the use of a prosthetic device. Benefits are available for external prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.

- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

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

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

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

Benefits are available for repairs and replacement when necessitated by anatomical change or normal use except that:

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

[26.] Reconstructive Procedures

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

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

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

Include when group purchases rehabilitation services benefit.

[1]Include when group purchases benefits for manipulative treatment.

[27.] [Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment]]

[Short-term outpatient rehabilitation services, limited to:

- Physical therapy.
- Occupational therapy.

[1]Include when group purchases benefits for manipulative treatment.

- [[1]Manipulative Treatment.]
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

- Post-cochlear implant aural therapy.

[2]Include when group purchases benefits for vision therapy.

- [[2]Vision therapy.]

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

[1]Include when group purchases benefits for manipulative treatment.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. [[1]Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.]

[1]Include when benefits are not provided for Neurobiological Disorders - Autism Spectrum Disorder Services. [2]Include when benefits are provided for Neurobiological Disorders - Autism Spectrum Disorder Services.

Please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or [[1]autism spectrum disorders] [[2]Autism Spectrum Disorders].]

[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic

[1]Include when plan design has an office visit copayment and supports paying the scopic benefit for services performed in a physician's office.

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

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

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

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

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

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design does not support paying the scopic procedures benefit for services performed in a physician's office.

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

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

[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

[1]Include if RAPLs and consulting physicians are paid under the facility charge.

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

[2]Include if RAPLs and consulting physicians are paid under the Physician fee category.

- [[2]Benefits for Physician services, including consulting Physicians, anesthesiologists, pathologists and radiologists, are described under *Physician Fees for Surgical and Medical Services*.]

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

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

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

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

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

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

Include when group purchases plan with SUD benefits.

[30.] [Substance Use Disorder Services]

[Substance Use Disorder Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits for Substance Use Disorder Services include:

- Substance Use Disorder and chemical dependency evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Detoxification (sub-acute/non-medical).
- Inpatient.

- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Referral services.
- Medication management.
- Individual, family and group therapeutic services.
- Crisis intervention.

[1]For groups not subject to Federal Parity requirements, include benefit conversion information if the group purchases option to convert inpatient days to intermediate care or transitional care. Delete for groups subject to Federal Parity requirements.

The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. [[1]When limits apply to inpatient or Intermediate Care services in the *Schedule of Benefits*, inpatient days may be converted to Intermediate Care (such as Partial Hospitalization/Day Treatment or Intensive Outpatient Treatment programs) or Transitional Care at the discretion of the Mental Health/Substance Use Disorder Designee.

One inpatient day is equivalent to:

[2]Adjust days according to plan parameters (standard is two sessions of partial hospitalization/day treatment; five sessions of intensive outpatient treatment; six outpatient visits; ten days of Transitional Care.

- One day at a Residential Treatment Facility.
- [[2]Two] sessions of Partial Hospitalization/Day Treatment.
- [[2]Five] sessions of Intensive Outpatient Treatment.
- [[2]Six] outpatient visits.
- [[2]Ten] days of Transitional Care.]

Referrals to a Substance Use Disorder Services provider are at the discretion of the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating all of your care.

Substance Use Disorder Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for *Substance Use Disorder Services*.

Special Substance Use Disorder Programs and Services

[1]Include for non-parity customers.

[2]Include for parity customers.

[3]Include if applicable.

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Substance Use Disorder Services Benefit. [[1]Depending on the type of programs or services available, the programs or services may be offered to you at no cost or as an exchange of Benefits. When offered as an exchange of Benefits for use of these programs or services, this exchange is based on the assignment of the program or service to either inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use and any associated Copayment, Coinsurance and deductible.] [[2]The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category

of Benefit use.] Special programs or services provide access to services that are beneficial for the treatment of your Substance Use Disorder which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care [[3]or through other pathways as described in the program introductions]. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.]

[31.] Surgery - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the outpatient surgery benefit for services performed in a physician's office.

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

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

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

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

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design supports paying the physician's office services benefit for outpatient surgery performed in a physician's office.

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

TMJ is mandated in Arkansas.

[32.] [Temporomandibular Joint Services]

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

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

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

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

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

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include *FDA*-approved TMJ implants only when all other treatment has failed.]

[33.] Therapeutic Treatments - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the therapeutic treatments benefit for services performed in a physician's office.

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office], including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

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

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

Benefits under this section include:

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

[2]Include when plan design supports paying the physician's office services benefit for therapeutic treatments performed in a physician's office.

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

[34.] Transplantation Services

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

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

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

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

[35.] Urgent Care Center Services

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

Include when group purchases benefits for vision exams.

[36.] [Vision Examinations]

[Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office.

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.]

Include when group purchases benefit for wigs.

[37.] [Wigs]

[Wigs and other scalp hair prosthesis regardless of the reason for hair loss.]

Additional Benefits Required By Arkansas Law

[38.] Dental Services - Anesthesia and Hospitalization

Covered Health Services for anesthesia and related hospital services in conjunction with a dental procedure, if the anesthesia and related hospital services are deemed medically necessary by the patient's Physician or dentist and the following conditions are met:

- The patient is a child age seven or younger who is diagnosed with a dental condition that requires certain dental procedures to be performed in a Hospital or Alternate Facility.
- The patient is diagnosed with a serious mental or physical condition or a significant behavioral problem as determined by the patient's Physician.

[39.] In Vitro Fertilization Services

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

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

[40.] Medical Foods

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

Include ONLY when group purchases plan with MH full parity. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing.

[[41.] Mental Health Services - Inpatient and Intermediate]

[Mental Health Services received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility.

- The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Mental Health Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. Referrals to a Mental Health Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for Inpatient/Intermediate Mental Health Services.]

Include ONLY when group purchases plan with MH full parity. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing.

[[42.] Mental Health Services - Outpatient]

[Mental Health Services received on an outpatient basis in a provider's office or at an Alternate Facility, including:

- Mental health evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Short-term individual, family and group therapeutic services (including intensive outpatient therapy).
- Crisis intervention.

Referrals to a Mental Health Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for outpatient Mental Health Services.]

This is a mandated offer in Arkansas. If group chooses not to have this benefit, they must refuse this benefit in writing.

[[43.] Musculoskeletal Disorders of the Face, Neck or Head]

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

Include ONLY when group purchases plan with inpatient/intermediate 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.

[[44.] Substance Abuse Services - Inpatient and Intermediate]

[Substance Abuse Services received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility.

[1]Include benefit conversion information if the group purchases option to convert inpatient days to intermediate care or transitional care.

The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. [[1]When limits apply to inpatient or Intermediate Care services in the *Schedule of Benefits*, inpatient days may be converted to Intermediate Care (such as partial hospitalization or intensive outpatient programs) or Transitional Care at the discretion of the Mental Health/Substance Abuse Designee.

One Inpatient day is equivalent to:

[2]Include first bullet only if customer purchases inpatient conversion to residential treatment.

- [[2]One day of residential treatment.]
- Two sessions of partial hospitalization/day treatment.

- Five sessions of intensive outpatient treatment.
- Six outpatient visits.
- Ten days of Transitional Care (either sober living or transitional living arrangements).]

Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. Referrals to a Substance Abuse Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for Inpatient/Intermediate Substance Abuse Services.]

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.

[[45.] Substance Abuse Services - Outpatient]

[Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including:

- Substance abuse and chemical dependency evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Short-term individual, family and group therapeutic services (including intensive outpatient therapy).
- Crisis intervention.

Referrals to a Substance Abuse Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for outpatient Substance Abuse Services.]

[[46.] Orthotic Devices and Services

Benefits are available for the evaluation and treatment of a condition that requires the use of an orthotic device.

Benefits are available for external orthotic devices that restore physiological function or cosmesis to you.

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

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

Benefits are available for repairs and replacement when necessitated by anatomical change or normal use except that:

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

Orthotic devices do not include a cane, crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that:

- Is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and
- Has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

This exclusion does not apply to orthotics that are described under Orthotic Devices and Services in Section 1: Covered Health Services.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

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

We do not Pay Benefits for Exclusions

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

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

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

Benefit Limitations

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

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

A. Alternative Treatments

[1]Remove acupuncture exclusion if group purchases acupuncture benefit.

1. Acupressure [[1]and acupuncture].
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.

[2]Include when group purchases benefits for manipulative treatment.

6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to [[2]Manipulative Treatment and] non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

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

Include when group purchases accidental dental benefit.

[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.] *Dental Services - Anesthesia and Hospitalization* for which Benefits are provided as described in *Section 1: Covered Health Services*.

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

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

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

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

Include when group purchases accidental dental benefit.

[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.] *Dental Services - Anesthesia and Hospitalization* for which Benefits are provided as described in *Section 1: Covered Health Services*.

Include when group purchases accidental dental benefit.

3. Dental implants, bone grafts, and other implant-related procedures. [This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.] *Dental Services - Anesthesia and Hospitalization* for which Benefits are provided as described in *Section 1: Covered Health Services*.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. This exclusion does not apply to orthotics as described under Durable Medical Equipment in Section 1: Covered Health Services.
3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

Include when the group purchases benefits for speech aid devices and tracheo-esophageal voice devices.

4. Devices and computers to assist in communication and speech [except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*].

5. Oral appliances for snoring.

Include when the group purchases benefits for prosthetics and delete variable exclusion #6 further below.

[6.] [Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.]

Include when the group purchases benefits for prosthetics.

[7.] [Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.]

Include when group does not purchase benefits for prosthetics and delete the variable exclusions #6 and 7 above.

[6.] [Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.]

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.

2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

E. Experimental or Investigational or Unproven Services

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

Include when the group purchases benefits for clinical trials.

[This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.]

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.

2. Nail trimming, cutting, or debriding.

3. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

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

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

[1]Include when group does not purchase benefits for durable medical equipment.

G. Medical Supplies [[1]and Equipment]

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

Include when group does not purchase benefits for ostomy supplies.

   - [Ostomy supplies.]

   This exclusion does not apply to:

Include only when group purchases benefits for durable medical equipment.

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

Include only when group purchases benefits for ostomy supplies.

   - [Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.]

[1]Include only when group purchases benefits for durable medical equipment.

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

Include when group does not purchase benefits for durable medical equipment.

[3.] [Medical equipment of any kind. This exclusion does not apply to insulin pumps for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.]

H. Mental Health

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

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

[2.] [Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.]*

[3.] [Mental Health Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.]

[4.] [Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.]

[5.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Use Disorder Designee.]

[6.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.]

[7.] [Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.]

[8.] [Learning, motor skills, and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

[9.] [Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

[1]Delete when group does not purchase MH benefits.

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

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

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

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

Include when plan does not include MH benefits.

[1]Include when the group provides MH benefits under a separate plan.

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

I. Neurobiological Disorders - Autism Spectrum Disorders

When group purchases autism coverage, keep exclusions 1-10 and delete exclusion #11. When group does not purchase autism coverage, keep exclusions 9 (except for the text variable) and 11, delete all remaining exclusions.

[1.] [Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

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

[3.] [Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.]

[4.] [Mental retardation as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

[5.] [Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.]

[6.] [Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.]

[7.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Use Disorder Designee.]

Delete when benefits are purchased for expanded autism spectrum disorder.

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

[1]Delete when group does not purchase MH benefits.

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

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

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

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

Include when plan does not include autism spectrum disorder benefits.

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

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

J. Nutrition

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

K. Personal Care, Comfort or Convenience

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

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

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

Delete when group purchases optional benefit for weight loss.

[5.] [Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.]

Delete if group purchases benefits for wigs.

[6.] [Wigs regardless of the reason for the hair loss.]

Preexisting Condition Exclusion. Retain exclusion below when group purchases preexisting condition exclusion. Delete entire exclusion when group does not select preexisting condition exclusion. (Also modify Section 9 by deleting definitions of Continuous Creditable Coverage and Preexisting Condition.)

[M. Preexisting Conditions]

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

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

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

[2]This paragraph will be included when group chooses to apply a 12-month preexisting condition exclusion to "timely adds" and an 18-month preexisting condition exclusion to Late Enrollees. If this applies, make corresponding changes related to Late Enrollees in Sections 3 and 9.

[1.] [[2]Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following:

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

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

[3]This paragraph will be included when group chooses to apply the preexisting condition exclusion to Late Enrollees only. If this applies, make corresponding changes related to Late Enrollees in Sections 3 and 9.

[4]Select either 12 or 18 month period.

[1.] [[3]Benefits for the treatment of a Preexisting Condition are excluded for Late Enrollees until the date you have had Continuous Creditable Coverage for [[4]12] [[4]18] months.

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

N. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

Include when group purchases rehabilitation services benefit. [1]Include when rehabilitation services category includes benefits for manipulative treatment.

[4.] [Rehabilitation services [[1]and Manipulative Treatment] to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including but not limited to routine, long-term or maintenance/preventive treatment.]

Include when group purchases rehabilitation services benefits.

[1]Include when benefits are not provided for Neurobiological Disorders - Autism Spectrum Disorder Services. [2]Include when benefits are provided for Neurobiological Disorders - Autism Spectrum Disorder Services.

[5.] [Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or [[1]autism spectrum disorders] [[2]Autism Spectrum Disorders].]

Include when group does not purchase rehabilitation services benefits.

[5.] [Outpatient rehabilitation services. Examples include physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy, manipulative treatment, post-cochlear implant aural therapy and vision therapy.]

[6.] Psychosurgery.

[7.] Sex transformation operations.

[8.] Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

[9.] Biofeedback.

Include when group purchases rehabilitation services benefits that do not include manipulative treatment.

[10.] [Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function).]

Include unless group purchases optional benefit for TMJ treatment.

[11.] [Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.]

Include when group purchases optional benefit for TMJ treatment.

[11.] [The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.]

[1]Include if group purchases optional benefit for Musculoskeletal Disorders.

[12.] Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea. [[1]This exclusion does not apply to Musculoskeletal Disorders of the Face, Neck or Head for which Benefits are provided as described in *Section 1: Covered Health Services* under *Additional Benefits Required By Arkansas Law*.]

Delete exclusion #12 below if the group purchases benefits for both obesity surgery and weight loss programs.

[1]Include when group does not purchase optional benefit for obesity treatment of any kind. [2]Include when group purchases optional benefit for obesity surgery, but not weight loss programs.[3]Include when group purchases optional benefit for only weight loss programs, but not obesity surgery.

[13.] [[1]Surgical and non-surgical treatment of obesity.] [[2]Non-surgical treatment of obesity.] [[3]Surgical treatment of obesity.]

Include unless group purchases smoking cessation benefits.

[14.] [Stand-alone multi-disciplinary smoking cessation programs.]

Include when group does not purchase optional benefit for Breast Reduction.

[15.] [Breast reduction except as coverage is required by the *Women's Health and Cancer Right's Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.]

Include when group purchases optional benefit for Breast Reduction.

[16.] [Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Right's Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.]

O. Providers

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

   This exclusion does not apply to mammography.

[1]Delete exclusion when benefits for infertility treatment are sold. [2]When Benefits for infertility treatment are sold, always delete the exclusion for fetal reduction surgery.

[3]Remove all bracketed text to provide benefits for voluntary sterilization, pregnancy termination, and contraceptive supplies and other services. For groups that choose to modify, remove brackets as applicable to describe which of these services the group has chosen to exclude.

P. Reproduction

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

[2]This paragraph will be included only when group purchases Infertility Services benefit. Delete if benefits for Infertility Services are not purchased.

   [[2]The following infertility treatment-related services:
   - Cryo-preservation and other forms of preservation of reproductive materials.
   - Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue.
   - Donor services.]
2. Surrogate parenting, donor eggs, donor sperm and host uterus.

[1]Include when group does not purchase infertility benefit.

3. [[1]Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.]

[4.] The reversal of voluntary sterilization [[3]and voluntary sterilization].

[5.] [[3]Health services and associated expenses for surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).]

[6.] [[3]Contraceptive supplies and services.]

[7.] [[3]Fetal reduction surgery.]

Include the following if group is excluding coverage for maternity benefits. This option is available only to groups with 14 or fewer employees.

[8.] [Maternity related medical services for prenatal care, postnatal care and delivery (other than a non-elective cesarean delivery).]

Include the following if group excludes maternity benefits for enrolled dependent children.

[9.] [Maternity related medical services for Enrolled Dependent children.]

Q. Services Provided under another Plan

[1]Include when 24 hour coverage is not sold and delete #4 (24 hour coverage option) below.

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

[2]Include when group purchases MH benefits. [3]Include when group does not purchase MH benefits.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or [[2]Mental Illness] [[3]mental illness] that would have been covered under workers' compensation or similar legislation had that coverage been elected.]

[4]Include when 24 hour coverage is sold and delete option #1 above.

[[4]Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.]

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

3. Health services while on active military duty.

R. Substance Use Disorders

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

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

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

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

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

[1]Delete when group does not purchase SUD benefits.

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

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

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

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

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

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

Include when plan does not include SUD benefits.

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

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

S. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.

Always include #4 for network only plans. For plans with Network and Non-Network benefits, include exclusion #4 when Non-Network transplant benefits are not available and plan design requires transplants to take place at Designated Facilities. Never include exclusion #4 for plans that do not differentiate benefits by network/non-network status.

[4.] [Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.]

T. Travel

Include as standard; delete when product design includes services provided outside the US and its territories.

1. [Health services provided in a foreign country, unless required as Emergency Health Services.]

[2.] Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion.

U. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care* in *Section 1: Covered Health Services*.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

V. Vision and Hearing

1. Purchase cost and fitting charge for eye glasses and contact lenses.

Include when group does not purchase benefits for vision exams.

[2.] [Routine vision examinations, including refractive examinations to determine the need for vision correction.]

[3.] Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

Delete exclusion when benefits for vision therapy are provided.

[4.] [Eye exercise or vision therapy.]

[5.] Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

Include as standard only for groups of 15+.

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

- For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

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

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

Include as standard for groups under 15.

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

W. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:

[1]Delete when Benefits are provided for immunizations for travel.

[2]Delete when Benefits are provided for immunizations for career and employment.

   - Required solely for purposes of school, sports or camp [[1], travel,] [[2]career or employment,] insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research.
   - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services.

Section 3: When Coverage Begins

How to Enroll

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

If You Are Hospitalized When Your Coverage Begins

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

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

Include if Medicare estimating applies.

[1]Include if Medicare estimating applies only to Medicare Parts A and B. [2]Include if Medicare estimating applies to Medicare Parts A, B and D. [3]Include if Medicare estimating applies only to Medicare Part D.

[If You Are Eligible for Medicare]

[Your Benefits under the Policy may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under [[1]both Medicare Part A and Part B] [[2]Medicare Part A, Part B and Part D] [[3]Medicare Part D].

Your Benefits under the Policy may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but fail to follow the rules of that plan. Please see *Medicare Eligibility* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.]

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Enrolling Group who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see *Section 9: Defined Terms*.

Include when U.S. residency is required.

[Eligible Persons must reside within the United States.]

Delete when group purchases double coverage.

[If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.]

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

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

Delete when group purchases double coverage.

[If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.]

When to Enroll and When Coverage Begins

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

Initial Enrollment Period

When the Enrolling Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

Include Open Enrollment Period unless a group chooses a closed plan.

[Open Enrollment Period]

[The Enrolling Group determines the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.]

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

[1]Include only if coverage is selected for domestic partners.

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- [[1]Registering a Domestic Partner.]

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

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

[1]*Include only if coverage is selected for domestic partners.*

[2]*Include when group chooses an Open Enrollment Period provision.*

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- [[1]Registering a Domestic Partner.]

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period [[2]or Open Enrollment Period] if the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period [[2]or Open Enrollment Period]; and
- Coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including, but not limited to, legal separation, divorce or death).
  - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  - In the case of COBRA continuation coverage, the coverage ended.
  - The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
  - The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
  - An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.
  - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth or marriage), coverage begins on the date of the event if we receive the completed enrollment form, any required Premium, and are notified within 90 days of the birth, 60 days of the adoption or placement for adoption or 31 days of the court or administrative order or marriage.

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For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period [[2]or Open Enrollment Period] because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Include if group chooses to allow Late Enrollees to enroll and applies the Late Enrollee preexisting condition. Make corresponding changes related to Late Enrollees in Sections 2 and 9.

[Late Enrollees]

[A Late Enrollee is an Eligible Person or Dependent who does not enroll for coverage under the Policy when he or she is first eligible, and who does not enroll during the Initial Enrollment Period [[2], Open Enrollment Period,] or a special enrollment period as described above.

Coverage for a Late Enrollee begins on the date agreed to by the Enrolling Group after we receive the completed enrollment form and any required Premium.]

Section 4: When Coverage Ends

General Information about When Coverage Ends

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

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. This does not apply if you are an inpatient in a Hospital on the date your coverage under the Policy would otherwise end as described under *Extended Coverage if You are Hospitalized*.

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

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

Include if Extended Coverage for Total Disability is included.

[Please note that for Covered Persons who are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.]

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

Throughout this section, select appropriate option for "date" or "last day of the calendar month in which" and delete the other.

- **You Are No Longer Eligible**

  Your coverage ends on the [date][last day of the calendar month in which] you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for complete definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

  Your coverage ends the [date][last day of the calendar month in which] the Subscriber is retired or receiving benefits under the Enrolling Group's pension or retirement plan. The Enrolling Group is responsible for providing written notice to us to end your coverage.

  This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is available for retirees.

Other Events Ending Your Coverage

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

- **Fraud, Misrepresentation or False Information**

  Fraud or misrepresentation, or the Subscriber knowingly gave us false material information. Examples include false information relating to another person's eligibility or status as a Dependent.

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

- **Material Violation**

  There was a material violation of the terms of the Policy.

- **Threatening Behavior**

  You committed acts of physical or verbal abuse that pose a threat to our staff.

Coverage for a Disabled Dependent Child

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

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Subscriber for support.

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

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

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

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Include when Full-time Student status is required for Dependents.

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

[Extended Coverage for Full-time Students]

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

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

Coverage will be extended only when the Enrolled Dependent is covered under the Policy because of Full-time Student status [[1]at a post-secondary school] immediately before the medically necessary leave

of absence begins and when the Enrolled Dependent's change in Full-time Student status meets all of the following requirements:

- The Enrolled Dependent is suffering from a serious Sickness or Injury.
- The leave of absence [[1]from the post-secondary school] is medically necessary, as determined by the Enrolled Dependent's treating Physician.
- The medically necessary leave of absence causes the Enrolled Dependent to lose Full-time Student status for purposes of coverage under the Policy.

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

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

Include when Enrolling Group purchases extended coverage.

[Extended Coverage for Total Disability]

[Coverage for a Covered Person who is Totally Disabled on the date the entire Policy is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.

[1]Insert applicable number of months.

- [[1]Three - Eighteen] months from the date coverage would have ended when the entire Policy was terminated.]

Extended Coverage if You are Hospitalized

This provision is applicable only if the Policy terminates and is replaced by a group health insurance policy or contract issued by another insurer or by a self-funded health care plan. However, the extension of coverage does not apply if termination of the Policy occurs due to non-payment of Premium or fraud.

If you are an inpatient in a Hospital or other inpatient facility on the date your coverage under the Policy would otherwise terminate as described in the paragraph above, coverage will be extended until the earlier of:

The date your Inpatient Stay ends, or

The date you have exhausted the Inpatient Stay benefits under the Policy.

Continuation of Coverage and Conversion

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Enrolling Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Qualifying Events for Continuation Coverage under State Law

Coverage must have ended due to one of the following qualifying events:

- Termination of the Subscriber from employment with the Enrolling Group for any reason except gross misconduct.
- Termination of coverage due to loss of eligibility as a Subscriber or an Enrolled Dependent.

Notification Requirements and Election Period for Continuation Coverage under State Law

The Enrolling Group will provide you with written notification of the right to continuation coverage when coverage ends under the Policy. You must elect continuation coverage after receiving this notification. You should obtain an election form from the Enrolling Group or the employer and, once election is made, forward all monthly Premiums to the Enrolling Group for payment to us.

Terminating Events for Continuation Coverage under State Law

Continuation coverage under the Policy will end on the earliest of the following dates:

- 120 days from the date your continuation began.
- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date coverage is or could be obtained under any other group health plan.
- The date the Policy ends.

Conversion

If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

Application and payment of the initial Premium must be made within 31 days after coverage ends under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

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

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

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

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

Required Information

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

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

[1]Include when Outpatient Prescription Drug Benefits are sold.

The above information should be filed with us at the address on your ID card. [[1]When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Include the name and address of the appropriate Pharmacy Benefit Manager.

[Name of Pharmacy Benefit Manager]

[Address of Pharmacy Benefit Manager]

[City, State and Zip Code]]

Payment of Benefits

[1]Include the following provision and delete option #2 below if assignment of benefits is agreed to.

[[1]If a Subscriber provides written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber. But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.]

Include the following provision and delete option #1 above if assignment of benefits is not agreed to.

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

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

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

Section 6: Questions, Complaints and Appeals

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

What to Do if You Have a Question

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

What to Do if You Have a Complaint

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

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

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

How to Appeal a Claim Decision

Post-service Claims

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

Pre-service Requests for Benefits

[1]Include if pre-service benefit notification includes determining alternate levels of benefits.

Pre-service requests for Benefits are those requests that require notification or benefit confirmation prior to receiving medical care. [[1]If we adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols and standard cost-effectiveness analysis, you may appeal that decision pursuant to this process.]

How to Request an Appeal

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

Your request for an appeal should include:

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

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

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination.

We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits.

Appeals Determinations

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

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

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

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

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

Urgent Appeals that Require Immediate Action

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

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

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

Voluntary External Review Program

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

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

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

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

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations

are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse.

(c) The Plan covering the non-Custodial Parent.

(d) The Plan covering the non-Custodial Parent's spouse.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Include if Medicare estimating applies.

[1]Include if Medicare estimating applies only to Medicare Parts A and B. [2]Include if Medicare estimating applies to Medicare Parts A, B and D. [3]Include if Medicare estimating applies only to Medicare Part D.

[C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare [[1]Parts A and B] [[2]Parts A, B and D] [[3]Part D].
- The person is enrolled in a *Medicare Advantage* (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits

are determined as if the services were covered under Medicare [[1]Parts A and B] [[2]Parts A, B and D] [[3]Part D].

- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare [[1]Parts A and B] [[2]Parts A, B and D] [[3]Part D] and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a *Medicare Medical Savings Account*. Medicare benefits are determined as if the person were covered under Medicare [[1]Parts A and B] [[2]Parts A, B and D] [[3]Part D].]

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Section 8: General Legal Provisions

Your Relationship with Us

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

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

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

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

Our Relationship with Providers and Enrolling Groups

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

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

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of the termination of the Policy.

When the Enrolling Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers and Enrolling Groups

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

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

The relationship between you and the Enrolling Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

Statements by Enrolling Group or Subscriber

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

Incentives to Providers

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

Examples of financial incentives for Network providers are:

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

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

Incentives to You

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

Rebates and Other Payments

[1]Include when rebates are passed on to Covered Persons. [2]Include when rebates are not passed on to Covered Persons.

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable Annual Deductible. We [[1]do] [[2]do not] pass these rebates on to you, [[1]and they are applied to any Annual Deductible and] [[2]nor are they applied to any Annual Deductible or] taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits

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

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

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

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

Administrative Services

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

Amendments to the Policy

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

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

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

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.

- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

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

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

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

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

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

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

Examination of Covered Persons

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

Workers' Compensation not Affected

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

Include if Medicare estimating applies.

[1]Include if Medicare estimating applies only to Medicare Parts A and B. [2]Include if Medicare estimating applies to Medicare Parts A, B and D. [3]Include if Medicare estimating applies only to Medicare Part D.

[Medicare Eligibility]

[Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Policy.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under [[1]both Medicare Part A and Part B] [[2]Medicare Parts A, B and D] [[3]Medicare Part D]. If you don't enroll and maintain that coverage, and if we are the secondary

payer as described in *Section 7: Coordination of Benefits*, we will pay Benefits under the Policy as if you were covered under [[1]both Medicare Part A and Part B] [[2]Medicare Parts A, B and D] [[3]Medicare Part D]. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.]

Subrogation and Reimbursement

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

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

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

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

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by us,
  - signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim,
  - responding to requests for information about any accident or injuries,
  - making court appearances, and
  - obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.

- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate, and your heirs.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

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

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

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable

under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

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

Entire Policy

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

Section 9: Defined Terms

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

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

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

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

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

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

Include only when an Annual Maximum Benefit applies.

[**Annual Maximum Benefit** - for Benefit plans that have an Annual Maximum Benefit, this is the maximum amount that we will pay for Benefits during the year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Annual Maximum Benefit and for details about how the Annual Maximum Benefit applies.]

Include when benefit for Infertility Services is sold.

[**Assisted Reproductive Technology (ART)** - the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).]

Include when benefits for Mental Health Services for Autism Spectrum Disorders are purchased.

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

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

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

Include when the group purchases benefits for complications of pregnancy.

[**Complications of Pregnancy** - a condition that requires treatment during a Pregnancy or during the post-partum period.]

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

Include definition for groups that purchase Preexisting Condition exclusion.

[**Continuous Creditable Coverage** - health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services, and for their dependents.
- A medical care program of the *Indian Health Services Program* or a tribal organization.
- A state health benefits risk pool.
- *The Federal Employees Health Benefits Program*.
- *The State Children's Health Insurance Program (S-CHIP)*.
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the *Peace Corps Act*.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.]

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

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

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

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

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, [[1]Mental Illness,][[2]mental illness,] substance use disorders, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.

- Described in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

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

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

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

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

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

[1]Include bracketed text if group purchases Domestic Partner coverage.

Dependent - the Subscriber's legal spouse or an unmarried dependent child of the Subscriber or the Subscriber's spouse. [[1]All references to the spouse of a Subscriber shall include a Domestic Partner.] The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

Include if group chooses to include the parents of the Subscriber as Dependents. [1]Include if group chooses to include the parents of the Subscriber's spouse as Dependents.

[The definition of Dependent also includes parents of the Subscriber [[1]or the Subscriber's spouse].]

Include when U.S. residency is required.

[To be eligible for coverage under the Policy, a Dependent must reside within the United States.]

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

[1]Modify age as appropriate to accommodate group decision.

- A Dependent includes any unmarried dependent child under [[1]18-19] years of age.

[2-3-4]Delete #2 if group does not use Full-time Student criteria and include #3 below for IRS criteria (cannot exceed age 24) or #4 if IRS criteria does not apply. Modify ages as appropriate to accommodate group decision.

- [[2]A Dependent includes an unmarried dependent child who is [[1]18 - 19] years of age or older, but less than [[1]23 - 30] years of age only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - The child must not be regularly employed on a full-time basis.
  - The child must be a Full-time Student.
  - The child must be primarily dependent upon the Subscriber for support and maintenance.]
- [[3]A Dependent includes an unmarried dependent child who is [[1]18 - 19] years of age or older, but less than [[1]23 - 24] years of age only if the child meets the Internal Revenue Service definition of a "qualifying child" or a "qualifying relative."]
- [[4]A Dependent includes an unmarried dependent child who is [[1]18 - 19] years of age or older, but less than [[1]23 - 30] years of age only if both of the following are true:
  - The child is not regularly employed on a full-time basis.
  - The child is primarily dependent upon the Subscriber for support and maintenance.]
- A Dependent includes an unmarried dependent child of any age who is or becomes disabled and dependent upon the Subscriber.

Include paragraph below when group intends to allow coverage for a dependent child until the last day of the year in which he/she reaches the limiting age. If different limits apply to Full-time Student, use language in that provision to address the full-time student criteria and the provision below to address the other dependent children.

[A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the child's [[1]18 - 30th] birthday.]

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

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

Include when the group does not elect double coverage.

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

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

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

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

Include following two definitions for groups that purchase domestic partner coverage.

Modify text for partners of the [1]"opposite sex,"[2]"same sex,"[3]"opposite or same sex."

[Domestic Partner - a person of the [[1]opposite sex][[2]same sex][[3]opposite or same sex] with whom the Subscriber has established a Domestic Partnership.]

[Domestic Partnership - a relationship between a Subscriber and one other person of the [[1]opposite sex][[2]same sex][[3]opposite or same sex]. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.

[1]Include if group requires documentation of financial interdependence. If necessary, modify conditions of financial interdependence to support group's requirements.

- They must be financially interdependent [[1]and they have furnished documents to support at least two of the following conditions of such financial interdependence:
  - They have a single dedicated relationship of at least [6 - 18] months duration.
  - They have joint ownership of a residence.
  - They have at least two of the following:
    - A joint ownership of an automobile.
    - A joint checking, bank or investment account.
    - A joint credit account.
    - A lease for a residence identifying both partners as tenants.
    - A will and/or life insurance policies which designates the other as primary beneficiary].

[2]Include if group requires signed affidavit.

[[2]The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.]]

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

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

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

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

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

[1]Include when U.S. residency is required.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. [[1]An Eligible Person must reside within the United States.]

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

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or [[1]Mental Illness][[2]mental illness] which is both of the following:

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

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

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

Enrolling Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

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

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

Exceptions:

Include when the group purchases benefits for clinical trials.

- [Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.]
- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for

that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

Include if extended dependent coverage requires Full-time Student status.

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

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

[1]Select option per group choice and delete others.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student [[1]at the end of the calendar month during which][[1]at the end of the calendar year during which][[1]on the date] you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

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

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

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

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

[1]Include when Benefits are provided only for MH Services. [2]Include when Benefits are provided only for SUD Services. [3]Include when Benefits are provided for both MH and SUD Services.

[Intensive Outpatient Treatment - a structured outpatient [[1]Mental Health][[3]or][[2]Substance Use Disorder] treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.]

Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

[1]Include when Benefits are provided only for MH Services. [2]Include when Benefits are provided only for SUD Services. [3]Include when Benefits are provided for both MH and SUD Services.

[Intermediate Care - [[1]Mental Health] [[3]or] [[2]Substance Use Disorder] treatment that encompasses the following:

- Care at a Residential Treatment Facility.
- Care at a Partial Hospitalization/Day Treatment program.
- Care through an Intensive Outpatient Treatment program.]

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Include definition of Late Enrollee if it has also been included in Section 2 and Section 3.

[**Late Enrollee** - an Eligible Person or Dependent who enrolls for coverage under the Policy at a time other than the following:

- During the Initial Enrollment Period.
- During an Open Enrollment Period.
- During a special enrollment period as described in *Section 3: When Coverage Begins*.
- Within 31 days of the date a new Eligible Person first becomes eligible.]

Low Protein Modified Food Product - a food product specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an Inherited Metabolic Disease under the direction of a Physician

Include when group purchases benefits for manipulative treatment.

[**Manipulative Treatment** -the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.]

Maximum Policy Benefit - for Benefit plans that have a Maximum Policy Benefit, this is the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Policy issued to the Enrolling Group. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to a Maximum Policy Benefit and for details about how the Maximum Policy Benefit applies.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Include when group purchases MH (including Neurobiological Disorders) coverage.

[Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.]

Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

[Mental Health/Substance Use Disorder Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.]

Include when group purchases MH (including Neurobiological Disorders) coverage.

[Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.]

[1]Always include unless the Shared Savings Program does not apply to Benefits under this COC. "Shared Savings Program" is bracketed to accommodate possible name change. The Shared Savings Program provision will not apply to Choice.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services [[1]by way of their participation in the [Shared Savings Program]]. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

Include when Open Enrollment is provided.

[Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.]

Orthotic Device - an external device that is, (i) intended to restore physiological function or cosmesis to a Covered Person; and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the Covered Person using the device prior to concurrent with the delivery of the device to the Covered Person.

Orthotic Service - the evaluation and treatment of a condition that requires the use of an Orthotic Device.

Prosthetic Device - an external device that is (i) intended to replace an external body part for the purpose of restoring physiological function or cosmesis to a patient; and (ii) custom designed, fabricated, assembled, fitted, or adjusted for patient using the device prior to or concurrent with being delivered to the Covered Person.

Prosthetic Service - the evaluation and treatment of a condition that requires the use of a Prosthetic Device.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

[Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.]

Include only when a per occurrence deductible applies.

[Per Occurrence Deductible - for Benefit plans that have a Per Occurrence Deductible, this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

When a Benefit plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of a Per Occurrence Deductible and for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.]

Pharmaceutical Product(s) - *FDA*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy*.
- This *Certificate*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Enrolling Group.

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Include definition if group has purchased a preexisting condition exclusion. [1]Select the appropriate "look back period."

[Preexisting Condition - an Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the [[1]three] [[1]six] month period ending on the person's enrollment date. (The enrollment date is the date the person became covered under the Policy or, if earlier, the first day of any waiting period under the Policy.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.]

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Include when benefit for Infertility Services is sold.

[Pre-implantation Genetic Diagnosis (PGD) - a screening test typically performed in conjunction with in vitro fertilization (IVF) in which one or two cells are removed from an embryo to be screened for genetic abnormalities.]

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

[1]Include when group purchases MH (including Neurobiological Disorders) or SUD coverage and all clinicians are considered primary physicians. [5]Include when clinicians providing psychological testing are not considered specialists. Delete #1 entirely when all clinicians are considered specialists.

[2]Include when group purchases MH benefits. [3]Include when group purchases SUD benefits. [4]Include when group purchases both MH and SUD benefits.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. [[1]For [[2]Mental Health Services] [[4]and] [[3]Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Primary Physician [[5]for the provision of all services other than psychological testing].]

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

[1]Include when Benefits are provided only for MH Services. [2]Include when Benefits are provided only for SUD Services. [3]Include when Benefits are provided for both MH and SUD Services.

[Residential Treatment Facility - a facility which provides a program of effective [[1]Mental Health Services] [[3]or] [[2]Substance Use Disorder Services] treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.]

Rider - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

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. The Shared Savings Program provision will not apply to Choice.

[[1][Shared Savings Program] - the [Shared Savings Program] provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the [Shared Savings Program] to pay claims when doing so will lower Eligible Expenses. We do not credential the [Shared Savings Program] providers and the [Shared Savings Program] providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by [Shared Savings Program] providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the [Shared Saving Program] to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.]

[1]Include when group purchases MH benefits (including Neurobiological Disorders). [2]Include when group does not purchase MH benefits.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* does not include [[1]Mental Illness][[2]mental illness] or substance use disorders, regardless of the cause or origin of the [[1]Mental Illness][[2]mental illness] or substance use disorder.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

[1]Include when group purchases MH (including Neurobiological Disorders) or SUD coverage and all clinicians are considered specialists.

[2]Include when group purchases MH (including Neurobiological Disorders) or SUD coverage and only clinicians that perform psychological testing are considered specialists.

[3]Include when group purchases MH benefits. [4]Include when group purchases SUD benefits. [5]Include when group purchases both MH and SUD benefits.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. [[1]For [[3]Mental Health Services] [[5]and] [[4]Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Specialist Physician.] [[2]For [[3]Mental Health Services] [[5]and] [[4]Substance Use Disorder Services], a licensed clinician who provides psychological testing is considered on the same basis as a Specialist Physician.]

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

Include when group purchases SUD benefits.

[Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.]

Include when Enrolling Group purchases extended coverage and when the corresponding provision has been retained in Section 4.

[Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.]

Include when group purchases MH (including Neurobiological Disorders) and SUD coverage.

[Transitional Care - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

Include when group purchases MH (including Neurobiological Disorders) but not SUD coverage.

[Transitional Care - Mental Health Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are supervised living arrangements which are residences that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - If the service is one that requires review by the *U.S. Food and Drug Administration (FDA)*, it must be *FDA*-approved.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
  - At least two studies must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
  - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Certificate of Coverage

UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy

This Certificate of Coverage (Certificate) is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this *Certificate* the Policy includes:

- The *Group Policy*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document

We may from time to time modify this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When that happens we will send you a new *Certificate*, Rider or Amendment pages.

No one can make any changes to the Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of Arkansas. The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of Arkansas are the laws that govern the Policy.

Introduction to Your Certificate

We are pleased to provide you with this *Certificate*. This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your *Certificate* and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 8: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this *Certificate* are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this *Certificate* and any summaries provided to you by the Enrolling Group, this *Certificate* will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*. You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your ID card. It will be our pleasure to assist you.

If we fail to provide you with reasonable and adequate service, you should feel free to contact the *Arkansas Insurance Department at*:

Arkansas Insurance Department

[Consumer Services Division]

[1200 West Third Street]

[Little Rock, AR 72201-1904]

[(800) 852-5494] or [(501) 371-2640]

Your Responsibilities

Be Enrolled and Pay Required Contributions

Benefits are available to you only if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled with us and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as a Subscriber or his or her Dependent as those terms are defined in *Section 9: Defined Terms*.

Your Enrolling Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy and receive Benefits. If you have questions about this, contact your Enrolling Group.

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Pay Your Share

You must pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Benefit plan's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Benefit plan for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in our discretion. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, in our sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this

prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider [by going to [www.myuhc.com] or] by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

[1]*Include when a Per Occurrence Deductible applies.*

- The amount you must pay for these Covered Health Services (including any Annual Deductible, [Per Occurrence Deductible,] Copayment and/or Coinsurance).

[1]*Include when an Annual Maximum Benefit applies.*

- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services[[1], any Annual Maximum Benefit,] and/or any Maximum Policy Benefit).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for notifying us or obtaining prior authorization.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

Include when group purchases benefits for acupuncture services.

[1.] [Acupuncture Services]

[Acupuncture services for the following conditions:

- Pain therapy.
- Nausea that is related to surgery, Pregnancy or chemotherapy.

Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.
- Acupuncturist.]

[2.] Ambulance Services

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

Include when group purchases benefits for clinical trials.

[3.] [Clinical Trials]

[Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer.
- Cardiovascular disease (cardiac/stroke).
- Surgical musculoskeletal disorders of the spine, hip, and knees.

Include to support expanding clinical trial benefit to other diseases or disorders.

- [Other diseases or disorders for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.]

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be a qualifying clinical trial, a clinical trial must meet all of the following criteria:

- Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.

- *Agency for Healthcare Research and Quality (AHRQ)*.
- *Centers for Medicare and Medicaid Services (CMS)*.
- *Department of Defense (DOD)*.
- *Veterans Administration (VA)*.

- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.]

Include when group purchases CHD benefit.

[4.] [Congenital Heart Disease Surgeries]

[Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include, but are not limited to, surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels, and hypoplastic left or right heart syndrome.

Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

We have specific guidelines regarding Benefits for CHD services. Contact us at the telephone number on your ID card for information about these guidelines.]

Include when group purchases accidental dental benefit.

[5.] [Dental Services - Accident Only]

[Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.

- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.]

[6.] Diabetes Services

Diabetes Self-Management Training is mandated in Arkansas.

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items

Include paragraph below when group purchases the drug rider.

[1]Include only when group purchases benefits for durable medical equipment.

[Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. [[1]An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment*.] Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider*.]

Include paragraph and bulleted list below when group does not purchase the drug rider.

[1]Include only when group does not purchase benefits for durable medical equipment.

[2]Include only when group purchases benefits for durable medical equipment.

[Insulin pumps [[1]that are not fully implanted into the body,] and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including, but not limited to:

- [[2]Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment*.]
- Blood glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.]

Include when group purchases durable medical equipment benefit.

[7.] [Durable Medical Equipment]

[Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.

- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece we have determined is the most cost-effective.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

Include when benefits for speech aid devices and tracheo-esophageal voice devices are sold.

[Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.]

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

Include when DME Benefit is tiered and tiers are not to be included in COC.

[To determine the Tiers to which Durable Medical Equipment are assigned, contact [www.myuhc.com] or *Customer Care* at the telephone number on your ID card.]

Include when DME Benefit is tiered and tiers are to be included in COC.

[Durable Medical Equipment in Tier 1 is any item not specifically outlined in Tiers 2 or 3 below.

Durable Medical Equipment in Tier 2 is limited to the items listed below and any necessary supplies:

- Oxygen.
- Tube feeding pumps.
- Negative pressure wound therapy pumps.
- Bi-level Positive Airway Pressure machines (BiPAPs).
- Bone growth stimulators.
- Pulse oximeters.
- Wearable automatic external defibrillators.
- Insulin pumps.
- Neuromuscular stimulators that we determine to be proven for use, and which are used as part of an approved rehabilitative program.

Include when benefits for speech aid devices and tracheo-esophageal voice devices are sold.

- [Speech aid devices and tracheo-esophageal voice devices.]

Durable Medical Equipment in Tier 3 is limited to the items listed below and any necessary supplies:

- Power wheel chairs.
- Ventilators.
- High frequency chest compression devices.
- Specialty beds for pressure reduction.]]

[8.] Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Include if plan design includes retrospective review of emergency services.

[Benefits under this section are not available for services to treat a condition that does not meet the

Include as standard only for groups of 15+.

[9.] [Hearing Aids]

[Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this *Certificate,* only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.

- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.]

[10.] Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

[11.] Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

[12.] Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

[1]Include if RAPLs and consulting physicians are paid under the facility charge.

- [[1]Physician services for anesthesiologists, Emergency room Physicians, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[2]Include if RAPLs and consulting physicians are paid under the Physician fee category.

- [[2]Emergency room Physicians. (Benefits for all other Physician services, including consulting Physicians, anesthesiologists, pathologists and radiologists, are described under *Physician Fees for Surgical and Medical Services*.)]

Include when group purchases benefits for infertility services.

[13.] [Infertility Services]

[Services for the treatment of infertility when provided by or under the direction of a Physician, limited to the following procedures:

- Ovulation induction.
- Insemination procedures (Artificial Insemination (AI) and IntraUterine Insemination (IUI)).
- Assisted Reproductive Technologies (ART).
- Pre-implantation Genetic Diagnosis (PGD) for diagnosis of genetic disorders only.
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

To be eligible for Benefits, the Covered Person must meet all of the following:

- Have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35.
- Be under age 44, if female.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.]

[14.] Lab, X-Ray and Diagnostics - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office.

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office] include, but are not limited to:

- Lab and radiology/X-ray.
- Mammography.

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design supports paying the physician's office services benefit for Lab/X-ray performed in a physician's office.

[[4]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

[15.] Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

[1]Include when plan design has an office visit copayment and supports paying CT, PET, MRI, MRA and nuclear medicine benefit for services performed in a physician's office.

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design supports paying the physician's office services benefit for major diagnostics performed in a physician's office.

[[4]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

Include when group purchases plan with 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]

[Mental Health Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits for Mental Health Services include:

- Mental health evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Inpatient.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Individual, family and group therapeutic services.
- Crisis intervention.

[1]For groups not subject to Federal Parity requirements, include benefit conversion information if the group purchases option to convert inpatient days to intermediate care or transitional care. Delete for groups subject to Federal Parity requirements.

The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. [[1]When limits apply to inpatient or Intermediate Care services in the *Schedule of Benefits*, inpatient days may be converted to Intermediate Care (such as Partial Hospitalization/Day Treatment or Intensive Outpatient Treatment programs) or Transitional Care at the discretion of the Mental Health/Substance Use Disorder Designee.

One inpatient day is equivalent to:

[2]Adjust days according to plan parameters (standard is two sessions of partial hospitalization/day treatment; five sessions of intensive outpatient treatment; six outpatient visits; ten days of Transitional Care.

- One day at a Residential Treatment Facility.
- [[2]Two] sessions of Partial Hospitalization/Day Treatment.
- [[2]Five] sessions of Intensive Outpatient Treatment.
- [[2]Six] outpatient visits.
- [[2]Ten] days of Transitional Care.]

Referrals to a Mental Health Services provider are at the discretion of the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating all of your care.

Mental Health Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for *Mental Health Services*.

Include when group purchases plan with inpatient/intermediate MH/SA 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

Special Mental Health Programs and Services

[1]Include for non-parity customers.

[2]Include for parity customers.

[3]Include if applicable.

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Mental Health Services Benefit. [[1]Depending on the type of programs or services available, the programs or services may be offered to you at no cost or as an exchange of Benefits. When offered as an exchange of Benefits for use of these programs or services, this exchange is based on the assignment of the program or service to either inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use and any associated Copayment, Coinsurance and deductible.] [[2]The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use.] Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care [[3]or through other pathways as described in the program introductions]. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.]

Include when group purchases plan with benefits for autism spectrum disorders. When Mental Health Benefits are included, core autism benefits will always be included because medical benefits for autism treatment are paid under the medical plan based on place of service (parity issue).

[17.] [Neurobiological Disorders - Autism Spectrum Disorder Services]

[Psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available [[1]under the applicable medical Covered Health Services categories in this *Certificate*] [[2]as described under [autism benefit section name] below].

Benefits include:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Inpatient/24-hour supervisory care.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Individual, family, therapeutic group, and provider-based case management services.
- Psychotherapy, consultation, and training session for parents and paraprofessional and resource support to family.
- Crisis intervention.
- Transitional Care.

Include when expanded services for autism are sold.

[Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).]

Autism Spectrum Disorder services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for *Neurobiological Disorders - Autism Spectrum Disorder Services*.]

Include when group purchases benefits for obesity surgery.

[18.] [Obesity Surgery]

[1]Include when specific criteria apply to benefits for obesity surgery and when only the criterion for a BMI of greater than 40 applies.

[Surgical treatment of obesity when provided by or under the direction of a Physician [[1]when the Covered Person has a Body Mass Index (BMI) of greater than 40].

[2]Include when specific criteria apply to benefits for obesity surgery and when either criterion must be met.

[[2]Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met:]

- [[2]The Covered Person must have a Body Mass Index (BMI) of greater than 40.]
- [[2]The Covered Person must have a Body Mass Index (BMI) of greater than 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by, obesity.]]

Include when group purchases benefits for ostomy supplies.

[19.] [Ostomy Supplies]

[Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.]

[1]Include when group purchases benefits for infertility services.

[20.] Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. [[1]Benefits under this section do not include medications for the treatment of infertility.]

Include only when benefits are tiered for Pharmaceutical Products.

[Pharmaceutical Products are assigned to various tiers. The *Prescription Drug List Management Committee* makes the final classification of a Pharmaceutical Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Pharmaceutical Product, as well as whether notification requirements should apply. Economic factors may include, but are not limited to, the Pharmaceutical Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Pharmaceutical Product.

NOTE: We may periodically change the placement of a Pharmaceutical Product among the tiers. These changes generally occur quarterly, but no more than six times per year. These changes may occur without prior notice to you. As a result of such changes, the tier status of a Pharmaceutical Product may change, and you may be required to pay more or less for that Pharmaceutical Product.

To determine the tiers to which Pharmaceutical Products are assigned, contact [www.myuhc.com] or *Customer Care* at the telephone number on your ID card. The amount that you are required to pay for Pharmaceutical Products will vary depending upon the tier to which the Pharmaceutical Product is assigned.]

Include when Step Therapy applies.

[Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical

Product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[21.] Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

[22.] Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include allergy injections.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

[1]Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office. [2]Include when only minor diagnostics are included under Physician's Office Services, but major diagnostics in a Physician's office are paid under the major diagnostic category.

[[1]Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. [[2]Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services.]]

[3]Include when plan design supports paying Benefits for lab/X-ray only under the Lab/X-ray benefit.

[[3]When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.]

[1]Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude.

[2]If Maternity Services are excluded, Complications of Pregnancy must always be included.

[23.] Pregnancy - [[1]Maternity Services] [[2]Complications of Pregnancy only]

[1]Include #1 below when Benefits are available for full Maternity Services and delete option #2 further below.

[[1]Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.]

[2]Include #2 below when Benefits are available only for Complications of Pregnancy and delete option #1 above.

[[2]Benefits for Complications of Pregnancy include all Covered Health Services required for the non-obstetrical treatment of a condition related to a Complication of Pregnancy during a Pregnancy or during the post-partum period.

Both before and during a Pregnancy, Benefits are provided for the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We will pay Benefits for an Inpatient Stay of at least 96 hours for the mother and newborn child following a non-elective cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than this minimum time frame.]

[24.] Preventive Care Services

Services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Examples of preventive medical care are:

Physician office services:

- Routine physical examinations.
- Well baby and well child care.
- Immunizations.
- Hearing screening.

Lab, X-ray or other preventive tests:

- Screening mammography.
- Screening colonoscopy or sigmoidoscopy.
- Cervical cancer screening.
- Prostate cancer screening.
- Bone mineral density tests.

Prosthetics is a mandated benefit in Arkansas.

[25.] Prosthetic Devices and Services

Benefits are available for the evaluation and treatment of a condition that requires the use of a prosthetic device. Benefits are available for external prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.

- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement when necessitated by anatomical change or normal use except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.]

[26.] Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

Include when group purchases rehabilitation services benefit.

[1]Include when group purchases benefits for manipulative treatment.

[27.] [Rehabilitation Services - Outpatient Therapy [[1]and Manipulative Treatment]]

[Short-term outpatient rehabilitation services, limited to:

- Physical therapy.
- Occupational therapy.

[1]Include when group purchases benefits for manipulative treatment.

- [[1]Manipulative Treatment.]
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

- Post-cochlear implant aural therapy.

[2]Include when group purchases benefits for vision therapy.

- [[2]Vision therapy.]

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

[1]Include when group purchases benefits for manipulative treatment.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. [[1]Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.]

[1]Include when benefits are not provided for Neurobiological Disorders - Autism Spectrum Disorder Services. [2]Include when benefits are provided for Neurobiological Disorders - Autism Spectrum Disorder Services.

Please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or [[1]autism spectrum disorders] [[2]Autism Spectrum Disorders].]

[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic

[1]Include when plan design has an office visit copayment and supports paying the scopic benefit for services performed in a physician's office.

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design does not support paying the scopic procedures benefit for services performed in a physician's office.

[[4]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

[1]Include if RAPLs and consulting physicians are paid under the facility charge.

- [[1]Physician services for anesthesiologists, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[2]Include if RAPLs and consulting physicians are paid under the Physician fee category.

- [[2]Benefits for Physician services, including consulting Physicians, anesthesiologists, pathologists and radiologists, are described under *Physician Fees for Surgical and Medical Services*.]

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Include when group purchases plan with SUD benefits.

[30.] [Substance Use Disorder Services]

[Substance Use Disorder Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits for Substance Use Disorder Services include:

- Substance Use Disorder and chemical dependency evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Detoxification (sub-acute/non-medical).
- Inpatient.

- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Referral services.
- Medication management.
- Individual, family and group therapeutic services.
- Crisis intervention.

[1]For groups not subject to Federal Parity requirements, include benefit conversion information if the group purchases option to convert inpatient days to intermediate care or transitional care. Delete for groups subject to Federal Parity requirements.

The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. [[1]When limits apply to inpatient or Intermediate Care services in the *Schedule of Benefits*, inpatient days may be converted to Intermediate Care (such as Partial Hospitalization/Day Treatment or Intensive Outpatient Treatment programs) or Transitional Care at the discretion of the Mental Health/Substance Use Disorder Designee.

One inpatient day is equivalent to:

[2]Adjust days according to plan parameters (standard is two sessions of partial hospitalization/day treatment; five sessions of intensive outpatient treatment; six outpatient visits; ten days of Transitional Care.

- One day at a Residential Treatment Facility.
- [[2]Two] sessions of Partial Hospitalization/Day Treatment.
- [[2]Five] sessions of Intensive Outpatient Treatment.
- [[2]Six] outpatient visits.
- [[2]Ten] days of Transitional Care.]

Referrals to a Substance Use Disorder Services provider are at the discretion of the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating all of your care.

Substance Use Disorder Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for *Substance Use Disorder Services*.

Special Substance Use Disorder Programs and Services

[1]Include for non-parity customers.

[2]Include for parity customers.

[3]Include if applicable.

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Substance Use Disorder Services Benefit. [[1]Depending on the type of programs or services available, the programs or services may be offered to you at no cost or as an exchange of Benefits. When offered as an exchange of Benefits for use of these programs or services, this exchange is based on the assignment of the program or service to either inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use and any associated Copayment, Coinsurance and deductible.] [[2]The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category

of Benefit use.] Special programs or services provide access to services that are beneficial for the treatment of your Substance Use Disorder which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care [[3]or through other pathways as described in the program introductions]. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.]

[31.] Surgery - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the outpatient surgery benefit for services performed in a physician's office.

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office].

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

[2]Include if RAPLs are paid under the facility charge.

[[2]Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[3]Include if RAPLs are paid under the Physician fee category.

[[3]Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services, including anesthesiologists, pathologists and radiologists are described under *Physician Fees for Surgical and Medical Services*.]

[4]Include when plan design supports paying the physician's office services benefit for outpatient surgery performed in a physician's office.

[[4]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

TMJ is mandated in Arkansas.

[32.] [Temporomandibular Joint Services]

[Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies, and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis, and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include *FDA*-approved TMJ implants only when all other treatment has failed.]

[33.] Therapeutic Treatments - Outpatient

[1]Include when plan design has an office visit copayment and supports paying the therapeutic treatments benefit for services performed in a physician's office.

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility [[1]or in a Physician's office], including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

[2]Include when plan design supports paying the physician's office services benefit for therapeutic treatments performed in a physician's office.

[[2]When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

[34.] Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

[35.] Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Include when group purchases benefits for vision exams.

[36.] [Vision Examinations]

[Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office.

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.]

Include when group purchases benefit for wigs.

[37.] [Wigs]

[Wigs and other scalp hair prosthesis regardless of the reason for hair loss.]

Additional Benefits Required By Arkansas Law

[38.] Dental Services - Anesthesia and Hospitalization

Covered Health Services for anesthesia and related hospital services in conjunction with a dental procedure, if the anesthesia and related hospital services are deemed medically necessary by the patient's Physician or dentist and the following conditions are met:

- The patient is a child age seven or younger who is diagnosed with a dental condition that requires certain dental procedures to be performed in a Hospital or Alternate Facility.
- The patient is diagnosed with a serious mental or physical condition or a significant behavioral problem as determined by the patient's Physician.

[39.] In Vitro Fertilization Services

Covered Health Services for in vitro fertilization services. Cryopreservation, the procedure whereby embryos are frozen for late implantation, will be included as an in vitro fertilization procedure. The coverage will include services performed at:

- A medical facility licensed or certified by the *Arkansas Department of Health*.
- A facility certified by the *Arkansas Department of Health* that conforms to the *American College of Obstetricians and Gynecologists* guidelines for in vitro fertilization clinics.
- A facility certified by the *Arkansas Department of Health* which meets the *American Fertility Society* minimal standards for programs of in vitro fertilization.

[40.] Medical Foods

Coverage for medical Foods and Low Protein Modified Food Products which are for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism and administered under the direction of a Physician is provided if the cost of the medical Foods and Low Protein Modified Food Products for an individual or a family with a Dependent person or persons exceeds the $2,400 per year, per person income tax credit. If the cost of these products does not exceed the per person income tax credit, Benefits are not provided.

Include ONLY when group purchases plan with MH full parity. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing.

[[41.] Mental Health Services - Inpatient and Intermediate]

[Mental Health Services received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility.

- The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Mental Health Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. Referrals to a Mental Health Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for Inpatient/Intermediate Mental Health Services.]

Include ONLY when group purchases plan with MH full parity. This is a mandated offer in Arkansas. If group chooses not to purchase this benefit, they must refuse this benefit in writing.

[[42.] Mental Health Services - Outpatient]

[Mental Health Services received on an outpatient basis in a provider's office or at an Alternate Facility, including:

- Mental health evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Short-term individual, family and group therapeutic services (including intensive outpatient therapy).
- Crisis intervention.

Referrals to a Mental Health Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for outpatient Mental Health Services.]

This is a mandated offer in Arkansas. If group chooses not to have this benefit, they must refuse this benefit in writing.

[[43.] Musculoskeletal Disorders of the Face, Neck or Head]

[Diagnosis and treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder, whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. Treatment will also include both surgical and non-surgical procedures. Coverage will be the same as that provided for any other musculoskeletal disorder in the body and will be provided whether prescribed or administered by a Physician or dentist.]

Include ONLY when group purchases plan with inpatient/intermediate 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.

[[44.] Substance Abuse Services - Inpatient and Intermediate]

[Substance Abuse Services received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility.

[1]Include benefit conversion information if the group purchases option to convert inpatient days to intermediate care or transitional care.

The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. [[1]When limits apply to inpatient or Intermediate Care services in the *Schedule of Benefits*, inpatient days may be converted to Intermediate Care (such as partial hospitalization or intensive outpatient programs) or Transitional Care at the discretion of the Mental Health/Substance Abuse Designee.

One Inpatient day is equivalent to:

[2]Include first bullet only if customer purchases inpatient conversion to residential treatment.

- [[2]One day of residential treatment.]
- Two sessions of partial hospitalization/day treatment.

- Five sessions of intensive outpatient treatment.
- Six outpatient visits.
- Ten days of Transitional Care (either sober living or transitional living arrangements).]

Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. Referrals to a Substance Abuse Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for Inpatient/Intermediate Substance Abuse Services.]

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.

[[45.] Substance Abuse Services - Outpatient]

[Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including:

- Substance abuse and chemical dependency evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Short-term individual, family and group therapeutic services (including intensive outpatient therapy).
- Crisis intervention.

Referrals to a Substance Abuse Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for outpatient Substance Abuse Services.]

[[46.] Orthotic Devices and Services

Benefits are available for the evaluation and treatment of a condition that requires the use of an orthotic device.

Benefits are available for external orthotic devices that restore physiological function or cosmesis to you.

If more than one orthotic device can meet your functional needs, Benefits are available only for the orthotic device that meets the minimum specifications for your needs. If you purchase a orthotic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the orthotic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The orthotic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement when necessitated by anatomical change or normal use except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen orthotic devices.

Orthotic devices do not include a cane, crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that:

- Is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and
- Has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

This exclusion does not apply to orthotics that are described under Orthotic Devices and Services in Section 1: Covered Health Services.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services* or through a Rider to the Policy.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

[1]Remove acupuncture exclusion if group purchases acupuncture benefit.

1. Acupressure [[1]and acupuncture].
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.

[2]Include when group purchases benefits for manipulative treatment.

6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to [[2]Manipulative Treatment and] non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

Include when group purchases accidental dental benefit.

[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.] *Dental Services - Anesthesia and Hospitalization* for which Benefits are provided as described in *Section 1: Covered Health Services*.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

Include when group purchases accidental dental benefit.

[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.] *Dental Services - Anesthesia and Hospitalization* for which Benefits are provided as described in *Section 1: Covered Health Services*.

Include when group purchases accidental dental benefit.

3. Dental implants, bone grafts, and other implant-related procedures. [This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.] *Dental Services - Anesthesia and Hospitalization* for which Benefits are provided as described in *Section 1: Covered Health Services*.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. This exclusion does not apply to orthotics as described under Durable Medical Equipment in Section 1: Covered Health Services.
3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

Include when the group purchases benefits for speech aid devices and tracheo-esophageal voice devices.

4. Devices and computers to assist in communication and speech [except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*].

5. Oral appliances for snoring.

Include when the group purchases benefits for prosthetics and delete variable exclusion #6 further below.

[6.] [Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.]

Include when the group purchases benefits for prosthetics.

[7.] [Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.]

Include when group does not purchase benefits for prosthetics and delete the variable exclusions #6 and 7 above.

[6.] [Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.]

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.

2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

Include when the group purchases benefits for clinical trials.

[This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.]

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.

2. Nail trimming, cutting, or debriding.

3. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

[1]Include when group does not purchase benefits for durable medical equipment.

G. Medical Supplies [[1]and Equipment]

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Elastic stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

Include when group does not purchase benefits for ostomy supplies.

   - [Ostomy supplies.]

   This exclusion does not apply to:

Include only when group purchases benefits for durable medical equipment.

   - [Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.]
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.

Include only when group purchases benefits for ostomy supplies.

   - [Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.]

[1]Include only when group purchases benefits for durable medical equipment.

2. Tubings and masks [[1]except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*].

Include when group does not purchase benefits for durable medical equipment.

[3.] [Medical equipment of any kind. This exclusion does not apply to insulin pumps for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.]

H. Mental Health

When group purchases MH coverage, keep exclusions 1-11 and delete exclusion #12. When group does not purchase MH coverage, keep exclusions 10 (except for the text variable) and 12, delete all remaining exclusions.

[1.] [Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

[2.] [Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.]*

[3.] [Mental Health Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.]

[4.] [Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.]

[5.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Use Disorder Designee.]

[6.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.]

[7.] [Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.]

[8.] [Learning, motor skills, and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

[9.] [Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

[1]Delete when group does not purchase MH benefits.

[10.] [Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements [[1], unless authorized by the Mental Health/Substance Use Disorder Designee].]

[11.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

The Mental Health/Substance Use Disorder Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.]

Include when plan does not include MH benefits.

[1]Include when the group provides MH benefits under a separate plan.

[12.] [Services for the treatment of mental illness or mental health conditions [[1]that the Enrolling Group has elected to provide through a separate benefit plan].]

I. Neurobiological Disorders - Autism Spectrum Disorders

When group purchases autism coverage, keep exclusions 1-10 and delete exclusion #11. When group does not purchase autism coverage, keep exclusions 9 (except for the text variable) and 11, delete all remaining exclusions.

[1.] [Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

[2.] [Autism Spectrum Disorder services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.]

[3.] [Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.]

[4.] [Mental retardation as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

[5.] [Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.]

[6.] [Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.]

[7.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Use Disorder Designee.]

Delete when benefits are purchased for expanded autism spectrum disorder.

[8.] [Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder.]

[1]Delete when group does not purchase MH benefits.

[9.] [Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements [[1], unless authorized by the Mental Health/Substance Use Disorder Designee].]

[10.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

The Mental Health/Substance Use Disorder Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.]

Include when plan does not include autism spectrum disorder benefits.

[1]Include when the group provides autism spectrum disorder benefits under a separate plan.

[11.] [Services for the treatment of autism spectrum disorders as the primary diagnosis [[1]that the Enrolling Group has elected to provide through a separate benefit plan]. (Autism spectrum disorders are a group of neurobiological disorders that includes *Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder,* and *Pervasive Development Disorders Not Otherwise Specified (PDDNOS).*)]

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
   - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2 Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to medical foods for which Benefits are provided as described in *Section 1: Covered Health Services*

3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters, dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps.
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.
   - Electric scooters.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot tubs.
   - Humidifiers.

- Jacuzzis.
- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

Delete when group purchases optional benefit for weight loss.

[5.] [Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.]

Delete if group purchases benefits for wigs.

[6.] [Wigs regardless of the reason for the hair loss.]

Preexisting Condition Exclusion. Retain exclusion below when group purchases preexisting condition exclusion. Delete entire exclusion when group does not select preexisting condition exclusion. (Also modify Section 9 by deleting definitions of Continuous Creditable Coverage and Preexisting Condition.)

[M. Preexisting Conditions]

[1]This paragraph will be included when group chooses to apply a 12 months preexisting condition exclusion to all Covered Persons.

[1.] [[1]Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months.

This exclusion does not apply to newborn children, newly adopted children or children placed for adoption. This exception for newborn, adopted children and children placed for adoption no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.]

[2]This paragraph will be included when group chooses to apply a 12-month preexisting condition exclusion to "timely adds" and an 18-month preexisting condition exclusion to Late Enrollees. If this applies, make corresponding changes related to Late Enrollees in Sections 3 and 9.

[1.] [[2]Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following:

- The date you have had Continuous Creditable Coverage for 12 months.
- The date you have had Continuous Creditable Coverage for 18 months if you are a Late Enrollee.

This exclusion does not apply to newborn children, newly adopted children or children placed for adoption. This exception for newborn, adopted children and children placed for adoption no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.]

[3]This paragraph will be included when group chooses to apply the preexisting condition exclusion to Late Enrollees only. If this applies, make corresponding changes related to Late Enrollees in Sections 3 and 9.

[4]Select either 12 or 18 month period.

[1.] [[3]Benefits for the treatment of a Preexisting Condition are excluded for Late Enrollees until the date you have had Continuous Creditable Coverage for [[4]12] [[4]18] months.

This exclusion does not apply to newborn children, newly adopted children or children placed for adoption. This exception for newborn, adopted children and children placed for adoption no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.]

N. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

Include when group purchases rehabilitation services benefit. [1]Include when rehabilitation services category includes benefits for manipulative treatment.

[4.] [Rehabilitation services [[1]and Manipulative Treatment] to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including but not limited to routine, long-term or maintenance/preventive treatment.]

Include when group purchases rehabilitation services benefits.

[1]Include when benefits are not provided for Neurobiological Disorders - Autism Spectrum Disorder Services. [2]Include when benefits are provided for Neurobiological Disorders - Autism Spectrum Disorder Services.

[5.] [Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or [[1]autism spectrum disorders] [[2]Autism Spectrum Disorders].]

Include when group does not purchase rehabilitation services benefits.

[5.] [Outpatient rehabilitation services. Examples include physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy, manipulative treatment, post-cochlear implant aural therapy and vision therapy.]

[6.] Psychosurgery.

[7.] Sex transformation operations.

[8.] Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

[9.] Biofeedback.

Include when group purchases rehabilitation services benefits that do not include manipulative treatment.

[10.] [Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function).]

Include unless group purchases optional benefit for TMJ treatment.

[11.] [Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.]

Include when group purchases optional benefit for TMJ treatment.

[11.] [The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.]

[1]Include if group purchases optional benefit for Musculoskeletal Disorders.

[12.] Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea. [[1]This exclusion does not apply to Musculoskeletal Disorders of the Face, Neck or Head for which Benefits are provided as described in *Section 1: Covered Health Services* under *Additional Benefits Required By Arkansas Law*.]

Delete exclusion #12 below if the group purchases benefits for both obesity surgery and weight loss programs.

[1]Include when group does not purchase optional benefit for obesity treatment of any kind. [2]Include when group purchases optional benefit for obesity surgery, but not weight loss programs.[3]Include when group purchases optional benefit for only weight loss programs, but not obesity surgery.

[13.] [[1]Surgical and non-surgical treatment of obesity.] [[2]Non-surgical treatment of obesity.] [[3]Surgical treatment of obesity.]

Include unless group purchases smoking cessation benefits.

[14.] [Stand-alone multi-disciplinary smoking cessation programs.]

Include when group does not purchase optional benefit for Breast Reduction.

[15.] [Breast reduction except as coverage is required by the *Women's Health and Cancer Right's Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.]

Include when group purchases optional benefit for Breast Reduction.

[16.] [Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Right's Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.]

O. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

[1]Delete exclusion when benefits for infertility treatment are sold. [2]When Benefits for infertility treatment are sold, always delete the exclusion for fetal reduction surgery.

[3]Remove all bracketed text to provide benefits for voluntary sterilization, pregnancy termination, and contraceptive supplies and other services. For groups that choose to modify, remove brackets as applicable to describe which of these services the group has chosen to exclude.

P. Reproduction

1. [[1]Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. except for In Vitro Fertilization Services for which Benefits are provided as described in *Section 1: Covered Health Services.* This exclusion does not apply to services required to treat or correct underlying causes of infertility.]

[2]This paragraph will be included only when group purchases Infertility Services benefit. Delete if benefits for Infertility Services are not purchased.

   [[2]The following infertility treatment-related services:
   - Cryo-preservation and other forms of preservation of reproductive materials.
   - Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue.
   - Donor services.]
2. Surrogate parenting, donor eggs, donor sperm and host uterus.

[1]Include when group does not purchase infertility benefit.

3. [[1]Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.]

[4.] The reversal of voluntary sterilization [[3]and voluntary sterilization].

[5.] [[3]Health services and associated expenses for surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).]

[6.] [[3]Contraceptive supplies and services.]

[7.] [[3]Fetal reduction surgery.]

Include the following if group is excluding coverage for maternity benefits. This option is available only to groups with 14 or fewer employees.

[8.] [Maternity related medical services for prenatal care, postnatal care and delivery (other than a non-elective cesarean delivery).]

Include the following if group excludes maternity benefits for enrolled dependent children.

[9.] [Maternity related medical services for Enrolled Dependent children.]

Q. Services Provided under another Plan

[1]Include when 24 hour coverage is not sold and delete #4 (24 hour coverage option) below.

1. [[1]Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

[2]Include when group purchases MH benefits. [3]Include when group does not purchase MH benefits.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or [[2]Mental Illness] [[3]mental illness] that would have been covered under workers' compensation or similar legislation had that coverage been elected.]

[4]Include when 24 hour coverage is sold and delete option #1 above.

[[4]Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.]

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

3. Health services while on active military duty.

R. Substance Use Disorders

When group purchases SUD coverage, keep exclusions 1-6 and delete exclusion #7. When group does not purchase SUD coverage, keep exclusions 5 (except for the text variable) and 7, delete all remaining exclusions.

[1.] [Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]

[2.] [Substance Use Disorder Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.]

[3.] [Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.]

[4.] [Substance Use Disorder Services for the treatment of nicotine or caffeine use.]

[1]Delete when group does not purchase SUD benefits.

[5.] [Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements [[1], unless authorized by the Mental Health/Substance Use Disorder Designee].]

[6.] [Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.

[1]Include when group purchases MH benefits. [2]Include when group does not purchase MH benefits.

- Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's [[1]Mental Illness] [[2]mental illness], substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

The Mental Health/Substance Use Disorder Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.]

Include when plan does not include SUD benefits.

[1]Include when the group provides SUD benefits under a separate plan.

[7.] [Services for the treatment of substance use disorder services [[1]that the Enrolling Group has elected to provide through a separate benefit plan].]

S. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.

Always include #4 for network only plans. For plans with Network and Non-Network benefits, include exclusion #4 when Non-Network transplant benefits are not available and plan design requires transplants to take place at Designated Facilities. Never include exclusion #4 for plans that do not differentiate benefits by network/non-network status.

[4.] [Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.]

T. Travel

Include as standard; delete when product design includes services provided outside the US and its territories.

1. [Health services provided in a foreign country, unless required as Emergency Health Services.]

[2.] Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion.

U. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care* in *Section 1: Covered Health Services*.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

V. Vision and Hearing

1. Purchase cost and fitting charge for eye glasses and contact lenses.

Include when group does not purchase benefits for vision exams.

[2.] [Routine vision examinations, including refractive examinations to determine the need for vision correction.]

[3.] Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

Delete exclusion when benefits for vision therapy are provided.

[4.] [Eye exercise or vision therapy.]

[5.] Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

Include as standard only for groups of 15+.

[6.] [Bone anchored hearing aids except when either of the following applies:

- For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy.

Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.]

Include as standard for groups under 15.

[6.] [Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.]

W. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:

[1]Delete when Benefits are provided for immunizations for travel.

[2]Delete when Benefits are provided for immunizations for career and employment.

   - Required solely for purposes of school, sports or camp [[1], travel,] [[2]career or employment,] insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research.
   - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services.

Section 3: When Coverage Begins

How to Enroll

Eligible Persons must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the completed forms to us, along with any required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

Include if Medicare estimating applies.

[1]Include if Medicare estimating applies only to Medicare Parts A and B. [2]Include if Medicare estimating applies to Medicare Parts A, B and D. [3]Include if Medicare estimating applies only to Medicare Part D.

[If You Are Eligible for Medicare]

[Your Benefits under the Policy may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under [[1]both Medicare Part A and Part B] [[2]Medicare Part A, Part B and Part D] [[3]Medicare Part D].

Your Benefits under the Policy may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but fail to follow the rules of that plan. Please see *Medicare Eligibility* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.]

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Enrolling Group who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see *Section 9: Defined Terms*.

Include when U.S. residency is required.

[Eligible Persons must reside within the United States.]

Delete when group purchases double coverage.

[If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.]

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

Delete when group purchases double coverage.

[If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.]

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Enrolling Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

Include Open Enrollment Period unless a group chooses a closed plan.

[Open Enrollment Period]

[The Enrolling Group determines the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.]

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

[1]Include only if coverage is selected for domestic partners.

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- [[1]Registering a Domestic Partner.]

Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption, court or administrative order, or marriage will take effect on the date of the event. Coverage is effective only if we receive any required Premium and are notified within 90 days of the birth, 60 days of the adoption or placement for adoption, or 31 days of the court or administrative order or marriage.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

[1]*Include only if coverage is selected for domestic partners.*

[2]*Include when group chooses an Open Enrollment Period provision.*

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- [[1]Registering a Domestic Partner.]

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period [[2]or Open Enrollment Period] if the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period [[2]or Open Enrollment Period]; and
- Coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including, but not limited to, legal separation, divorce or death).
  - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  - In the case of COBRA continuation coverage, the coverage ended.
  - The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
  - The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
  - An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.
  - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth or marriage), coverage begins on the date of the event if we receive the completed enrollment form, any required Premium, and are notified within 90 days of the birth, 60 days of the adoption or placement for adoption or 31 days of the court or administrative order or marriage.

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For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period [[2]or Open Enrollment Period] because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Include if group chooses to allow Late Enrollees to enroll and applies the Late Enrollee preexisting condition. Make corresponding changes related to Late Enrollees in Sections 2 and 9.

[Late Enrollees]

[A Late Enrollee is an Eligible Person or Dependent who does not enroll for coverage under the Policy when he or she is first eligible, and who does not enroll during the Initial Enrollment Period [[2], Open Enrollment Period,] or a special enrollment period as described above.

Coverage for a Late Enrollee begins on the date agreed to by the Enrolling Group after we receive the completed enrollment form and any required Premium.]

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. This does not apply if you are an inpatient in a Hospital on the date your coverage under the Policy would otherwise end as described under *Extended Coverage if You are Hospitalized*.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Include if Extended Coverage for Total Disability is included.

[Please note that for Covered Persons who are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.]

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

Throughout this section, select appropriate option for "date" or "last day of the calendar month in which" and delete the other.

- **You Are No Longer Eligible**

  Your coverage ends on the [date][last day of the calendar month in which] you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for complete definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the [date][last day of the calendar month in which] we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.

- **Subscriber Retires or Is Pensioned**

  Your coverage ends the [date][last day of the calendar month in which] the Subscriber is retired or receiving benefits under the Enrolling Group's pension or retirement plan. The Enrolling Group is responsible for providing written notice to us to end your coverage.

  This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is available for retirees.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Subscriber that coverage has ended on the date we identify in the notice:

- **Fraud, Misrepresentation or False Information**

  Fraud or misrepresentation, or the Subscriber knowingly gave us false material information. Examples include false information relating to another person's eligibility or status as a Dependent.

  During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

- **Material Violation**

  There was a material violation of the terms of the Policy.

- **Threatening Behavior**

  You committed acts of physical or verbal abuse that pose a threat to our staff.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Subscriber for support.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency as described above, coverage for that child will end.

Include when Full-time Student status is required for Dependents.

[1]Include when extended coverage applies only to Full-time Students at a post-secondary school. Delete if extended coverage applies also to high school students.

[Extended Coverage for Full-time Students]

[Coverage for an Enrolled Dependent child who is a Full-time Student [[1]at a post-secondary school] and who needs a medically necessary leave of absence will be extended until the earlier of the following:

- One year after the medically necessary leave of absence begins.
- The date coverage would otherwise terminate under the Policy.

Coverage will be extended only when the Enrolled Dependent is covered under the Policy because of Full-time Student status [[1]at a post-secondary school] immediately before the medically necessary leave of absence begins and when the Enrolled Dependent's change in Full-time Student status meets all of the following requirements:

- The Enrolled Dependent is suffering from a serious Sickness or Injury.
- The leave of absence [[1]from the post-secondary school] is medically necessary, as determined by the Enrolled Dependent's treating Physician.

- The medically necessary leave of absence causes the Enrolled Dependent to lose Full-time Student status for purposes of coverage under the Policy.

A written certification by the treating Physician is required. The certification must state that the Enrolled Dependent child is suffering from a serious Sickness or Injury and that the leave of absence is medically necessary.

For purposes of this extended coverage provision, the term "leave of absence" includes any change in enrollment [[1]at the post-secondary school] that causes the loss of Full-time Student status.]

Include when Enrolling Group purchases extended coverage.

[Extended Coverage for Total Disability]

[Coverage for a Covered Person who is Totally Disabled on the date the entire Policy is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.

[1]Insert applicable number of months.

- [[1]Three - Eighteen] months from the date coverage would have ended when the entire Policy was terminated.]

Extended Coverage if You are Hospitalized

This provision is applicable only if the Policy terminates and is replaced by a group health insurance policy or contract issued by another insurer or by a self-funded health care plan. However, the extension of coverage does not apply if termination of the Policy occurs due to non-payment of Premium or fraud.

If you are an inpatient in a Hospital or other inpatient facility on the date your coverage under the Policy would otherwise terminate as described in the paragraph above, coverage will be extended until the earlier of:

The date your Inpatient Stay ends, or

The date you have exhausted the Inpatient Stay benefits under the Policy.

Continuation of Coverage and Conversion

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Enrolling Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.

- Notifying us in a timely manner of your election of continuation coverage.

Qualifying Events for Continuation Coverage under State Law

Coverage must have ended due to one of the following qualifying events:

- Termination of the Subscriber from employment with the Enrolling Group for any reason except gross misconduct.
- Termination of coverage due to loss of eligibility as a Subscriber or an Enrolled Dependent.

Notification Requirements and Election Period for Continuation Coverage under State Law

The Enrolling Group will provide you with written notification of the right to continuation coverage when coverage ends under the Policy. You must elect continuation coverage after receiving this notification. You should obtain an election form from the Enrolling Group or the employer and, once election is made, forward all monthly Premiums to the Enrolling Group for payment to us.

Terminating Events for Continuation Coverage under State Law

Continuation coverage under the Policy will end on the earliest of the following dates:

- 120 days from the date your continuation began.
- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date coverage is or could be obtained under any other group health plan.
- The date the Policy ends.

Conversion

If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

Application and payment of the initial Premium must be made within 31 days after coverage ends under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable Annual Deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, in our discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

[1]Include when Outpatient Prescription Drug Benefits are sold.

The above information should be filed with us at the address on your ID card. [[1]When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Include the name and address of the appropriate Pharmacy Benefit Manager.

[Name of Pharmacy Benefit Manager]

[Address of Pharmacy Benefit Manager]

[City, State and Zip Code]]

Payment of Benefits

[1]Include the following provision and delete option #2 below if assignment of benefits is agreed to.

[[1]If a Subscriber provides written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber. But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.]

Include the following provision and delete option #1 above if assignment of benefits is not agreed to.

[[2]You may not assign your Benefits under the Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Subscriber) for

you to reimburse them upon receipt of their bill. We may, however, in our discretion, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.]

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How to Appeal a Claim Decision

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

[1]Include if pre-service benefit notification includes determining alternate levels of benefits.

Pre-service requests for Benefits are those requests that require notification or benefit confirmation prior to receiving medical care. [[1]If we adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols and standard cost-effectiveness analysis, you may appeal that decision pursuant to this process.]

How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination or post-service claim determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination.

We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Voluntary External Review Program

After you exhaust the appeal process, if we make a final determination to deny Benefits, you may choose to participate in our voluntary external review program. This program only applies if our decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental or Investigational or Unproven Services.

The external review program is not available if our coverage determinations are based on Benefit exclusions or defined Benefit limits.

Contact us at the telephone number shown on your ID card for more information on the voluntary external review program.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations

are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse.

(c) The Plan covering the non-Custodial Parent.

(d) The Plan covering the non-Custodial Parent's spouse.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Include if Medicare estimating applies.

[1]Include if Medicare estimating applies only to Medicare Parts A and B. [2]Include if Medicare estimating applies to Medicare Parts A, B and D. [3]Include if Medicare estimating applies only to Medicare Part D.

[C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare [[1]Parts A and B] [[2]Parts A, B and D] [[3]Part D].
- The person is enrolled in a *Medicare Advantage* (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits

are determined as if the services were covered under Medicare [[1]Parts A and B] [[2]Parts A, B and D] [[3]Part D].

- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare [[1]Parts A and B] [[2]Parts A, B and D] [[3]Part D] and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a *Medicare Medical Savings Account*. Medicare benefits are determined as if the person were covered under Medicare [[1]Parts A and B] [[2]Parts A, B and D] [[3]Part D].]

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We do not decide what care you need or will receive. You and your Physician make those decisions.
- We communicate to you decisions about whether the Enrolling Group's Benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this *Certificate*.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of the termination of the Policy.

When the Enrolling Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers and Enrolling Groups

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Enrolling Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

[1]Include when rebates are passed on to Covered Persons. [2]Include when rebates are not passed on to Covered Persons.

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable Annual Deductible. We [[1]do] [[2]do not] pass these rebates on to you, [[1]and they are applied to any Annual Deductible and] [[2]nor are they applied to any Annual Deductible or] taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits

We have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.

- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Include if Medicare estimating applies.

[1]Include if Medicare estimating applies only to Medicare Parts A and B. [2]Include if Medicare estimating applies to Medicare Parts A, B and D. [3]Include if Medicare estimating applies only to Medicare Part D.

[Medicare Eligibility]

[Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Policy.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under [[1]both Medicare Part A and Part B] [[2]Medicare Parts A, B and D] [[3]Medicare Part D]. If you don't enroll and maintain that coverage, and if we are the secondary

payer as described in *Section 7: Coordination of Benefits*, we will pay Benefits under the Policy as if you were covered under [[1]both Medicare Part A and Part B] [[2]Medicare Parts A, B and D] [[3]Medicare Part D]. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.]

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this *Certificate*, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by us,
  - signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim,
  - responding to requests for information about any accident or injuries,
  - making court appearances, and
  - obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.

- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate, and your heirs.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*, the Enrolling Group's application, and any Riders and/or Amendments, constitutes the entire Policy.

Section 9: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

[1]Include when group purchases MH (including Neurobiological Disorders) or SUD coverage. [2]Include when Benefits are provided only for MH Services. [3]Include when Benefits are provided only for SUD Services. [4]Include when Benefits are provided for both MH and SUD Services.

[[1]An Alternate Facility may also provide [[2]Mental Health Services] [[4]or] [[3]Substance Use Disorder Services] on an outpatient or inpatient basis.]

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

Include only when an Annual Maximum Benefit applies.

[**Annual Maximum Benefit** - for Benefit plans that have an Annual Maximum Benefit, this is the maximum amount that we will pay for Benefits during the year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Annual Maximum Benefit and for details about how the Annual Maximum Benefit applies.]

Include when benefit for Infertility Services is sold.

[**Assisted Reproductive Technology (ART)** - the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).]

Include when benefits for Mental Health Services for Autism Spectrum Disorders are purchased.

[**Autism Spectrum Disorders** - a group of neurobiological disorders that includes *Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder,* and *Pervasive Development Disorders Not Otherwise Specified (PDDNOS)*.]

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits*, and any attached Riders and/or Amendments.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Include when the group purchases benefits for complications of pregnancy.

[**Complications of Pregnancy** - a condition that requires treatment during a Pregnancy or during the post-partum period.]

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Include definition for groups that purchase Preexisting Condition exclusion.

[**Continuous Creditable Coverage** - health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services, and for their dependents.
- A medical care program of the *Indian Health Services Program* or a tribal organization.
- A state health benefits risk pool.
- *The Federal Employees Health Benefits Program*.
- *The State Children's Health Insurance Program (S-CHIP)*.
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the *Peace Corps Act*.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.]

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

[1]Include when group purchases MH (including Neurobiological Disorders). [2]Include when group does not purchase MH benefits.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, [[1]Mental Illness,][[2]mental illness,] substance use disorders, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.

- Described in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

We maintain clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical protocols (as revised from time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this *Certificate* are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

[1]Include bracketed text if group purchases Domestic Partner coverage.

Dependent - the Subscriber's legal spouse or an unmarried dependent child of the Subscriber or the Subscriber's spouse. [[1]All references to the spouse of a Subscriber shall include a Domestic Partner.] The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

Include if group chooses to include the parents of the Subscriber as Dependents. [1]Include if group chooses to include the parents of the Subscriber's spouse as Dependents.

[The definition of Dependent also includes parents of the Subscriber [[1]or the Subscriber's spouse].]

Include when U.S. residency is required.

[To be eligible for coverage under the Policy, a Dependent must reside within the United States.]

The definition of Dependent is subject to the following conditions and limitations:

[1]Modify age as appropriate to accommodate group decision.

- A Dependent includes any unmarried dependent child under [[1]18-19] years of age.

[2-3-4]Delete #2 if group does not use Full-time Student criteria and include #3 below for IRS criteria (cannot exceed age 24) or #4 if IRS criteria does not apply. Modify ages as appropriate to accommodate group decision.

- [[2]A Dependent includes an unmarried dependent child who is [[1]18 - 19] years of age or older, but less than [[1]23 - 30] years of age only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - The child must not be regularly employed on a full-time basis.
  - The child must be a Full-time Student.
  - The child must be primarily dependent upon the Subscriber for support and maintenance.]
- [[3]A Dependent includes an unmarried dependent child who is [[1]18 - 19] years of age or older, but less than [[1]23 - 24] years of age only if the child meets the Internal Revenue Service definition of a "qualifying child" or a "qualifying relative."]
- [[4]A Dependent includes an unmarried dependent child who is [[1]18 - 19] years of age or older, but less than [[1]23 - 30] years of age only if both of the following are true:
  - The child is not regularly employed on a full-time basis.
  - The child is primarily dependent upon the Subscriber for support and maintenance.]
- A Dependent includes an unmarried dependent child of any age who is or becomes disabled and dependent upon the Subscriber.

Include paragraph below when group intends to allow coverage for a dependent child until the last day of the year in which he/she reaches the limiting age. If different limits apply to Full-time Student, use language in that provision to address the full-time student criteria and the provision below to address the other dependent children.

[A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the child's [[1]18 - 30th] birthday.]

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

Include when the group does not elect double coverage.

[A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.]

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Include following two definitions for groups that purchase domestic partner coverage.

Modify text for partners of the [1]"opposite sex,"[2]"same sex,"[3]"opposite or same sex."

[Domestic Partner - a person of the [[1]opposite sex][[2]same sex][[3]opposite or same sex] with whom the Subscriber has established a Domestic Partnership.]

[Domestic Partnership - a relationship between a Subscriber and one other person of the [[1]opposite sex][[2]same sex][[3]opposite or same sex]. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.

[1]Include if group requires documentation of financial interdependence. If necessary, modify conditions of financial interdependence to support group's requirements.

- They must be financially interdependent [[1]and they have furnished documents to support at least two of the following conditions of such financial interdependence:
  - They have a single dedicated relationship of at least [6 - 18] months duration.
  - They have joint ownership of a residence.
  - They have at least two of the following:
    - A joint ownership of an automobile.
    - A joint checking, bank or investment account.
    - A joint credit account.
    - A lease for a residence identifying both partners as tenants.
    - A will and/or life insurance policies which designates the other as primary beneficiary].

[2]Include if group requires signed affidavit.

[[2]The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.]]

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

[1]Include when U.S. residency is required.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. [[1]An Eligible Person must reside within the United States.]

[1]Include when group purchases MH benefits. [2]Include when group does not purchase MH benefits.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or [[1]Mental Illness][[2]mental illness] which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Enrolling Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

Include when the group purchases benefits for clinical trials.

- [Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.]
- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for

that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

Include if extended dependent coverage requires Full-time Student status.

[Full-time Student - a person who is enrolled in and attending, full-time, a recognized course of study or training at one of the following:

- An accredited high school.
- An accredited college or university.
- A licensed vocational school, technical school, cosmetology school, automotive school or similar training school.

[1]Select option per group choice and delete others.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student [[1]at the end of the calendar month during which][[1]at the end of the calendar year during which][[1]on the date] you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If you do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.]

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

[1]Include when Benefits are provided only for MH Services. [2]Include when Benefits are provided only for SUD Services. [3]Include when Benefits are provided for both MH and SUD Services.

[Intensive Outpatient Treatment - a structured outpatient [[1]Mental Health][[3]or][[2]Substance Use Disorder] treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.]

Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

[1]Include when Benefits are provided only for MH Services. [2]Include when Benefits are provided only for SUD Services. [3]Include when Benefits are provided for both MH and SUD Services.

[Intermediate Care - [[1]Mental Health] [[3]or] [[2]Substance Use Disorder] treatment that encompasses the following:

- Care at a Residential Treatment Facility.
- Care at a Partial Hospitalization/Day Treatment program.
- Care through an Intensive Outpatient Treatment program.]

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Include definition of Late Enrollee if it has also been included in Section 2 and Section 3.

[**Late Enrollee** - an Eligible Person or Dependent who enrolls for coverage under the Policy at a time other than the following:

- During the Initial Enrollment Period.
- During an Open Enrollment Period.
- During a special enrollment period as described in *Section 3: When Coverage Begins*.
- Within 31 days of the date a new Eligible Person first becomes eligible.]

Low Protein Modified Food Product - a food product specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an Inherited Metabolic Disease under the direction of a Physician

Include when group purchases benefits for manipulative treatment.

[**Manipulative Treatment** -the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.]

Maximum Policy Benefit - for Benefit plans that have a Maximum Policy Benefit, this is the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Policy issued to the Enrolling Group. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to a Maximum Policy Benefit and for details about how the Maximum Policy Benefit applies.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Include when group purchases MH (including Neurobiological Disorders) coverage.

[Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.]

Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

[Mental Health/Substance Use Disorder Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.]

Include when group purchases MH (including Neurobiological Disorders) coverage.

[Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.]

[1]Always include unless the Shared Savings Program does not apply to Benefits under this COC. "Shared Savings Program" is bracketed to accommodate possible name change. The Shared Savings Program provision will not apply to Choice.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services [[1]by way of their participation in the [Shared Savings Program]]. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

Include when Open Enrollment is provided.

[Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.]

Orthotic Device - an external device that is, (i) intended to restore physiological function or cosmesis to a Covered Person; and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the Covered Person using the device prior to concurrent with the delivery of the device to the Covered Person.

Orthotic Service - the evaluation and treatment of a condition that requires the use of an Orthotic Device.

Prosthetic Device - an external device that is (i) intended to replace an external body part for the purpose of restoring physiological function or cosmesis to a patient; and (ii) custom designed, fabricated, assembled, fitted, or adjusted for patient using the device prior to or concurrent with being delivered to the Covered Person.

Prosthetic Service - the evaluation and treatment of a condition that requires the use of a Prosthetic Device.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

[Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.]

Include only when a per occurrence deductible applies.

[Per Occurrence Deductible - for Benefit plans that have a Per Occurrence Deductible, this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

When a Benefit plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of a Per Occurrence Deductible and for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.]

Pharmaceutical Product(s) - *FDA*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy*.
- This *Certificate*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Enrolling Group.

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Include definition if group has purchased a preexisting condition exclusion. [1]Select the appropriate "look back period."

[Preexisting Condition - an Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the [[1]three] [[1]six] month period ending on the person's enrollment date. (The enrollment date is the date the person became covered under the Policy or, if earlier, the first day of any waiting period under the Policy.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.]

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Include when benefit for Infertility Services is sold.

[Pre-implantation Genetic Diagnosis (PGD) - a screening test typically performed in conjunction with in vitro fertilization (IVF) in which one or two cells are removed from an embryo to be screened for genetic abnormalities.]

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

[1]Include when group purchases MH (including Neurobiological Disorders) or SUD coverage and all clinicians are considered primary physicians. [5]Include when clinicians providing psychological testing are not considered specialists. Delete #1 entirely when all clinicians are considered specialists.

[2]Include when group purchases MH benefits. [3]Include when group purchases SUD benefits. [4]Include when group purchases both MH and SUD benefits.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. [[1]For [[2]Mental Health Services] [[4]and] [[3]Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Primary Physician [[5]for the provision of all services other than psychological testing].]

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

[1]Include when Benefits are provided only for MH Services. [2]Include when Benefits are provided only for SUD Services. [3]Include when Benefits are provided for both MH and SUD Services.

[Residential Treatment Facility - a facility which provides a program of effective [[1]Mental Health Services] [[3]or] [[2]Substance Use Disorder Services] treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.]

Rider - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

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. The Shared Savings Program provision will not apply to Choice.

[[1][Shared Savings Program] - the [Shared Savings Program] provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the [Shared Savings Program] to pay claims when doing so will lower Eligible Expenses. We do not credential the [Shared Savings Program] providers and the [Shared Savings Program] providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by [Shared Savings Program] providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the [Shared Saving Program] to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.]

[1]Include when group purchases MH benefits (including Neurobiological Disorders). [2]Include when group does not purchase MH benefits.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* does not include [[1]Mental Illness][[2]mental illness] or substance use disorders, regardless of the cause or origin of the [[1]Mental Illness][[2]mental illness] or substance use disorder.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

[1]Include when group purchases MH (including Neurobiological Disorders) or SUD coverage and all clinicians are considered specialists.

[2]Include when group purchases MH (including Neurobiological Disorders) or SUD coverage and only clinicians that perform psychological testing are considered specialists.

[3]Include when group purchases MH benefits. [4]Include when group purchases SUD benefits. [5]Include when group purchases both MH and SUD benefits.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. [[1]For [[3]Mental Health Services] [[5]and] [[4]Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Specialist Physician.] [[2]For [[3]Mental Health Services] [[5]and] [[4]Substance Use Disorder Services], a licensed clinician who provides psychological testing is considered on the same basis as a Specialist Physician.]

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

Include when group purchases SUD benefits.

[Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.]

Include when Enrolling Group purchases extended coverage and when the corresponding provision has been retained in Section 4.

[Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.]

Include when group purchases MH (including Neurobiological Disorders) and SUD coverage.

[Transitional Care - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

Include when group purchases MH (including Neurobiological Disorders) but not SUD coverage.

[Transitional Care - Mental Health Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are supervised living arrangements which are residences that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - If the service is one that requires review by the *U.S. Food and Drug Administration (FDA)*, it must be *FDA*-approved.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
  - At least two studies must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
  - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.