

SERFF Tracking Number: UHLC-126551161 State: Arkansas
Filing Company: United HealthCare Insurance Company State Tracking Number: 45216
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: 2009 AR Federal Legislation Benefit Summary Filing
Project Name/Number: /

Filing at a Glance

Company: United HealthCare Insurance Company

Product Name: 2009 AR Federal Legislation SERFF Tr Num: UHLC-126551161 State: Arkansas

Benefit Summary Filing

TOI: H21 Health - Other

SERFF Status: Closed-Approved-
Closed

State Tr Num: 45216

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: 04/01/2010

Date Submitted: 03/21/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type:

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 04/01/2010

Explanation for Other Group Market Type:

State Status Changed: 04/01/2010

Deemer Date:

Created By: Ebony Terry

Submitted By: Ebony Terry

Corresponding Filing Tracking Number:

Filing Description:

2009 AR Federal Legislation Benefit Summary Filing

Company and Contact

Filing Contact Information

Ebony Terry, Compliance Analyst

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301-838-5611 [Phone]

Rockville, MD 20850

301-838-5676 [FAX]

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Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: 3 forms x fee
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United HealthCare Insurance Company	\$150.00	03/21/2010	35043093

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/01/2010	04/01/2010

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Disposition

Disposition Date: 04/01/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Benefit Summary	Approved-Closed	Yes
Form	Benefit Summary	Approved-Closed	Yes
Form	Benefit Summary	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/01/2010	BENSUM. GENRX.PL S.I.09.AR	Outline of Coverage	Benefit Summary	Initial			AR 2007 Federal Legislation INS GENERIC RX Plus_3 .19. 10.pdf
Approved-Closed 04/01/2010	BENSUM.R X.PLS.I.09. AR	Outline of Coverage	Benefit Summary	Initial			AR 2007 Federal Legislation INS RX Plus _3.19.10.pdf
Approved-Closed 04/01/2010	BENSUMS HAREPLS.I. .09.AR	Outline of Coverage	Benefit Summary	Initial			AR 2007 Federal Legislation INS SHARED RX Plus _ 3.19.10.pdf

Benefit Summary

Outpatient Prescription Drug

Arkansas

[Plan Description] -Plan [XX]

Your Copayment and/or Coinsurance is determined by the generic status of the Prescription Drug Product. Benefits are available only for generic designated products unless otherwise state mandated. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to www.myuhc.com® or calling the Customer Care number on your ID card. [This state requires coverage of certain brand name medications. The medications that are classified as brands, will be charged a higher copay than generic coverage.]

[Annual [Drug] Deductible – [Network] [and] [Non-Network]]

[Individual Deductible]	[No Annual Drug Deductible] [\$XX] [See Medical Benefit Summary] [Deductible does not apply to [Tier 1][and][Tier 2][Tier 3][and][Tier 4]]
[Family Deductible]	[No Annual Drug Deductible] [\$XX] [See Medical Benefit Summary] [Deductible does not apply to [Tier 1][and][Tier 2][Tier 3][and][Tier 4]]

[Out-of-Pocket [Drug] Maximum – [Network] [and] [Non-Network]]

[Individual Out-of-Pocket Maximum]	[\$XX] [See Medical Benefit Summary]
[Family Out-of-Pocket Maximum]	[\$XX] [See Medical Benefit Summary] [Copayments and Coinsurance for Prescription Drug Products are not limited by an Out-of-Pocket Drug Maximum.] [The Out-of-Pocket Drug Maximum [includes] [does not include] the Annual Drug Deductible.]

[A Deductible and Out-of-Pocket Maximum may apply. Please refer to the medical plan documents for the Annual Deductible and Out-of-Pocket Maximum amounts, which include both medical and pharmacy expenses. This means that you will pay the full amount we have contracted with the pharmacy to charge for your prescriptions (not just your Copayment), until you have satisfied the Deductible. Once the Deductible is satisfied, your prescriptions will be subject to the Copayments and/or Coinsurance outlined below. If you reach the Out-of-Pocket Maximum, you will not be required to pay a Copayment.]

This summary of Benefits is intended only to highlight your Benefits for Generic Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

[Item #] [Rev. Date] [Plan Name]
[XXX-XXXX] [XX/XX] [XXXXXXXXXX]

UnitedHealthcare Insurance Company

YOUR BENEFITS

Tier Level	Retail [Up to 31-day supply]	[Mail Order]**[*] [Up to 90-day supply]	
	Network	[Non-Network]**[*]	[Network]
<p>Tier 1</p>	<p>[[XX][XX]% of the Prescription Drug Cost [after you pay a Copayment of \$[XX]] per Prescription Order or Refill [, except that we pay [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[XX]] [,] [and] [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[XX]] [, and] [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[XX]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[XX]] [you will not pay more than \$[XX]] [you will not pay less than \$[XX]] and you will not pay more than \$[XX]] per Prescription Order or Refill.][No Copayment]</p>	<p>[[XX][XX]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[XX]] per Prescription Order or Refill [, except that we pay [[XX]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[XX]] [,] [and] [[XX]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[XX]] [, and] [[XX]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[XX]] per Prescription Order or Refill]. [However,] [you will not pay less than \$[XX]] [you will not pay more than \$[XX]] [you will not pay less than \$[XX]] and you will not pay more than \$[XX]] per Prescription Order or Refill.][No Copayment]</p>	<p>[[XX] [XX]% of the Prescription Drug Cost [after you pay a Copayment of \$[XX]] per Prescription Order or Refill [, except that we pay [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A][after you pay a Copayment of \$[XX]]], [and] [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B][after you pay a Copayment of \$[XX]]], and] [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C][after you pay a Copayment of \$[XX]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[XX]] [you will not pay more than \$[XX]] [you will not pay less than \$[XX]] and you will not pay more than \$[XX]] per Prescription Order or Refill.][No Copayment]</p>
<p>Tier 2</p>	<p>[[XX][XX]% of the Prescription Drug Cost [after you pay a Copayment of \$[XX]] per Prescription Order or Refill [, except that we pay [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[XX]]</p>	<p>[[XX][XX]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[XX]] per Prescription Order or Refill [, except that we pay [[XX]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A]</p>	<p>[[XX] [XX]% of the Prescription Drug Cost [after you pay a Copayment of \$[XX]] per Prescription Order or Refill[, except that we pay [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A][after you pay a Copayment of \$[XX]]], [and] [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [, and] [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C][after you pay a Copayment of</p>

YOUR BENEFITS

	<p>[,] [and] [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[XX]] [, and] [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[XX]] per Prescription Order or Refill]. [[However,] [you will not pay less than [\$XX]] [you will not pay more than [\$XX]] [you will not pay less than [\$XX] and you will not pay more than [\$XX]] per Prescription Order or Refill.][No Copayment]</p>	<p>[after you pay a Copayment of \$[XX]] [,] [and] [[XX]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[XX]] [, and] [[XX]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[XX]] per Prescription Order or Refill]. [However,] [you will not pay less than [\$XX]] [you will not pay more than [\$XX]] [you will not pay less than [\$XX] and you will not pay more than [\$XX]] per Prescription Order or Refill.][No Copayment]</p>	<p>\$[XX]] per Prescription Order or Refill]. [[However,] [you will not pay less than [\$XX]] [you will not pay more than [\$XX]] [you will not pay less than [\$XX] and you will not pay more than [\$XX]] per Prescription Order or Refill.][No Copayment]</p>
<p>[Tier 3]</p>	<p>[[XX][XX]% of the Prescription Drug Cost [after you pay a Copayment of \$[XX]] per Prescription Order or Refill [, except that we pay [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[XX]] [,] [and] [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[XX]] [, and] [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[XX]] per Prescription Order or Refill]. [[However,] [you will not pay less</p>	<p>[[XX][XX]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[XX]] per Prescription Order or Refill [, except that we pay [[XX]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[XX]] [,] [and] [[XX]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[XX]] [, and] [[XX]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a</p>	<p>[[XX] [XX]% of the Prescription Drug Cost [after you pay a Copayment of \$[XX]] per Prescription Order or Refill[, except that we pay [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A][after you pay a Copayment of \$[XX]][,][and] [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B][after you pay a Copayment of \$[XX]][, and] [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C][after you pay a Copayment of \$[XX]] per Prescription Order or Refill]. [[However,] [you will not pay less than [\$XX]] [you will not pay more than [\$XX]] [you will not pay less than [\$XX] and you will not pay more than [\$XX]] per Prescription Order or Refill.][No Copayment]</p>

YOUR BENEFITS

	<p>than [\$XX] [you will not pay more than [\$XX] [you will not pay less than [\$XX] and you will not pay more than [\$XX] per Prescription Order or Refill.]] [No Copayment]</p>	<p>Copayment of \$[XX]] per Prescription Order or Refill]. [However,] [you will not pay less than [\$XX] [you will not pay more than [\$XX] [you will not pay less than [\$XX] and you will not pay more than [\$XX] per Prescription Order or Refill.]] [No Copayment]</p>	
<p>[Tier 4]</p>	<p>[[XX][XX]% of the Prescription Drug Cost [after you pay a Copayment of \$[XX]] per Prescription Order or Refill [, except that we pay [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[XX]] [,] [and] [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[XX]] [, and] [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[XX]] per Prescription Order or Refill]. [[However,] [you will not pay less than [\$XX] [you will not pay more than [\$XX] [you will not pay less than [\$XX] and you will not pay more than [\$XX] per Prescription Order or Refill.]] [No Copayment]</p>	<p>[[XX][XX]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[XX]] per Prescription Order or Refill [, except that we pay [[XX]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[XX]] [,] [and] [[XX]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[XX]] [, and] [[XX]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[XX]] per Prescription Order or Refill]. [However,] [you will not pay less than [\$XX] [you will not pay more than [\$XX] [you will not pay less than [\$XX] and you will not pay more than [\$XX] per Prescription Order or Refill.]] No Copayment]</p>	<p>[[XX] [XX]% of the Prescription Drug Cost [after you pay a Copayment of \$[XX]] per Prescription Order or Refill[, except that we pay [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [A][after you pay a Copayment of \$[XX]][,][and] [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [B][, and] [[XX]% of the Prescription Drug Cost for a Prescription Drug Product for Therapeutic Class [C][after you pay a Copayment of \$[XX]] per Prescription Order or Refill]. [[However,] [you will not pay less than [\$XX] [you will not pay more than [\$XX] [you will not pay less than [\$XX] and you will not pay more than [\$XX] per Prescription Order or Refill.]] [No Copayment]</p>

[*Brand name drugs reside on tier 2 and 3. Please go to myuhc.com to determine tier status for specific drugs]

YOUR BENEFITS

[**] Only certain Prescription Drug Products are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on the back of your ID card for more information.]

[**]Note: If you purchase a Prescription Drug Product from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount we would have paid for the same Prescription Drug Product dispensed by a Network Pharmacy.]

Other Important Information about your Outpatient Prescription Drug Benefits

You are responsible for paying the lower of the applicable Copayment and/or Coinsurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment and/or Coinsurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Supply limits apply to Specialty Prescription Drug Products whether obtained at a retail pharmacy or through a mail order pharmacy.

Some Prescription Drug Products or Pharmaceutical Products for which Benefits are described under the Prescription Drug Rider or 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.

Also note that some Prescription Drug Products require that you notify us in advance to determine whether the Prescription Drug Product meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

If you require certain 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 the Designated Pharmacy, [you will be subject to the Non-Network Benefit for that Prescription Drug Product] [no Benefit will be paid for that Prescription Drug Product].

PHARMACY EXCLUSIONS

Exclusions from coverage listed in the Certificate apply also to this Rider [except any pre-existing condition exclusion in the Certificate is not applicable to this Rider]. In addition, the exclusions listed below apply.

Exclusions

- Brand-name Prescription Drug Products which are not otherwise specifically stated in this Rider as covered.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- [Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.]
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- 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.
- 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.
- 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.
- [Any product dispensed for the purpose of appetite suppression or weight loss.]
- A Pharmaceutical Product for which Benefits are provided in your Certificate. [This exclusion does not apply to covered injectable drugs used for contraception.] [This exclusion does not apply to immunizations administered in a [Network] [,] [non-Network] [Network or non-Network] [or] [a Designated] Pharmacy.]
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging of Prescription Drug Products.
- Medications used for cosmetic purposes.
- 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.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products when prescribed to treat infertility.
- [Prescription Drug Products when prescribed to prevent conception, including, but not limited to, oral contraceptives, diaphragms, and injectable drugs used for contraception.]
- [Treatment for toenail Onychomycosis (toenail fungus).]
- [Prescription Drug Products for smoking cessation.]
- [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.]
- [A Prescription Drug Product prescribed by a non-Network Physician or other non-Network provider.]
- Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.
- [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

YOUR BENEFITS

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.][This exclusion does not apply to over-the-counter drugs used for smoking cessation.]

- [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.]
- Growth hormone therapy.
- [Any oral non-sedating antihistamine or antihistamine-decongestant combination.]
- [Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.]
- 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.
- [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.]
- [Prescription Drug Products when prescribed as sleep aids.]
- [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.]
- [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.]

Benefit Summary

Outpatient Prescription Drug

Arkansas – [Plan Description] -Plan [XX]

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[,] [or] [Tier 2][,] [or] [Tier 3] [or] [Tier 4]. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to www.myuhc.com® or calling Customer Care at the telephone number on the back of your ID card.

[Annual [Drug] Deductible – [Network] [and] [Non-Network]]

[Individual Deductible]	[No Annual Drug Deductible] [\$XX] [See Medical Benefit Summary] [Deductible does not apply to [Tier 1][and][Tier 2][Tier 3][and][Tier 4]]
[Family Deductible]	[No Annual Drug Deductible] [\$XX] [See Medical Benefit Summary] [Deductible does not apply to [Tier 1][and][Tier 2][Tier 3][and][Tier 4]]

[Out-of-Pocket [Drug] Maximum – [Network] [and] [Non-Network]]

[Individual Out-of-Pocket Maximum]	[No Out-of-Pocket Drug Maximum] [\$XX] [See Medical Benefit Summary]
[Family Out-of-Pocket Maximum]	[No Out-of-Pocket Drug Maximum] [\$XX] [See Medical Benefit Summary] [Copayments and Coinsurance for Prescription Drug Products are not limited by an Out-of-Pocket Drug Maximum.] [The Out-of-Pocket Drug Maximum [includes] [does not include] the Annual Drug Deductible.]

[A Deductible and Out-of-Pocket Maximum may apply. Please refer to the medical plan documents for the Annual Deductible and Out-of-Pocket Maximum amounts, which include both medical and pharmacy expenses. This means that you will pay the full amount we have contracted with the pharmacy to charge for your prescriptions (not just your Copayment), until you have satisfied the Deductible. Once the Deductible is satisfied, your prescriptions will be subject to the Copayments and/or Coinsurance outlined below. If you reach the Out-of-Pocket Maximum, you will not be required to pay a Copayment.]

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug Product expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

[Item #] [Rev. Date] [Plan Name]

YOUR BENEFITS

[XXX-XXXX] [XX/XX] [XXXXXXXXXX]

UnitedHealthcare Insurance Company

Tier Level	Retail [Up to 31-day supply]		* [Mail Order] [Up to 90-day supply]
	Network	[Non-Network]	[Network]
Tier 1	[[$\$XX$][XX] % of the Prescription Drug Cost [after you pay a Copayment of $\$XX$] per Prescription Order or Refill. [[However,] [you will not pay less than $\$XX$] [you will not pay more than $\$XX$] [you will not pay less than $\$XX$] and you will not pay more than $\$XX$] per Prescription Order or Refill.]] [No Copayment]	[[$\$XX$][XX] % of the Predominant Reimbursement Rate [after you pay a Copayment of $\$XX$] per Prescription Order or Refill [However,] [you will not pay less than $\$XX$] [you will not pay more than $\$XX$] [you will not pay less than $\$XX$] and you will not pay more than $\$XX$] per Prescription Order or Refill.]] [No Copayment]	[[$\$XX$] [XX] % of the Prescription Drug Cost [after you pay a Copayment of $\$XX$] per Prescription Order or Refill. [[However,] [you will not pay less than $\$XX$] [you will not pay more than $\$XX$] [you will not pay less than $\$XX$] and you will not pay more than $\$XX$] per Prescription Order or Refill.]] [No Copayment]
Tier 2	[[$\$XX$][XX] % of the Prescription Drug Cost [after you pay a Copayment of $\$XX$] per Prescription Order or Refill. [[However,] [you will not pay less than $\$XX$] [you will not pay more than $\$XX$] [you will not pay less than $\$XX$] and you will not pay more than $\$XX$] per Prescription Order or Refill.]] [No Copayment]	[[$\$XX$][XX] % of the Predominant Reimbursement Rate [after you pay a Copayment of $\$XX$] per Prescription Order or Refill [However,] [you will not pay less than $\$XX$] [you will not pay more than $\$XX$] [you will not pay less than $\$XX$] and you will not pay more than $\$XX$] per Prescription Order or Refill.]] [No Copayment]	[[$\$XX$] [XX] % of the Prescription Drug Cost [after you pay a Copayment of $\$XX$] per Prescription Order or Refill. [[However,] [you will not pay less than $\$XX$] [you will not pay more than $\$XX$] [you will not pay less than $\$XX$] and you will not pay more than $\$XX$] per Prescription Order or Refill.]] [No Copayment]
[Tier 3]	[[$\$XX$][XX] % of the Prescription Drug Cost [after you pay a Copayment of $\$XX$] per Prescription Order or Refill. [[However,] [you will not pay less than $\$XX$] [you will not pay more than $\$XX$] [you will not pay less than $\$XX$] and you will not pay more than $\$XX$] per Prescription Order or Refill.]] [No Copayment]	[[$\$XX$][XX] % of the Predominant Reimbursement Rate [after you pay a Copayment of $\$XX$] per Prescription Order or Refill [However,] [you will not pay less than $\$XX$] [you will not pay more than $\$XX$] [you will not pay less than $\$XX$] and you will not pay more than $\$XX$] per Prescription Order or Refill.]] [No Copayment]	[[$\$XX$] [XX] % of the Prescription Drug Cost [after you pay a Copayment of $\$XX$] per Prescription Order or Refill. [[However,] [you will not pay less than $\$XX$] [you will not pay more than $\$XX$] [you will not pay less than $\$XX$] and you will not pay more than $\$XX$] per Prescription Order or Refill.]] [No Copayment]
[Tier 4]	[[$\$XX$][XX] % of the Prescription Drug Cost	[[$\$XX$][XX] % of the Predominant	[[$\$XX$] [XX] % of the Prescription Drug Cost [after you pay a Copayment of

YOUR BENEFITS

	[after you pay a Copayment of \$[XX]] per Prescription Order or Refill. [[However,] [you will not pay less than [XX]] [you will not pay more than [XX]] [you will not pay less than [XX]] and you will not pay more than [XX]] per Prescription Order or Refill.][No Copayment]	Reimbursement Rate [after you pay a Copayment of \$[XX]] per Prescription Order or Refill [However,] [you will not pay less than [XX]] [you will not pay more than [XX]] [you will not pay less than [XX]] and you will not pay more than [XX]] per Prescription Order or Refill.][No Copayment]	\$[XX] per Prescription Order or Refill. [[However,] [you will not pay less than [XX]] [you will not pay more than [XX]] [you will not pay less than [XX]] and you will not pay more than [XX]] per Prescription Order or Refill.][No Copayment]
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* Only certain Prescription Drug Products are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on the back of your ID card for more information.

[Note: If you purchase a Prescription Drug Product from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount we would have paid for the same Prescription Drug Product dispensed by a Network Pharmacy.]

Other Important Information about your Outpatient Prescription Drug Benefits

You are responsible for paying the lower of the applicable Copayment and/or Coinsurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment and/or Coinsurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Supply limits apply to Specialty Prescription Drug Products whether obtained at a retail pharmacy or through a mail order pharmacy.

Some Prescription Drug Products or Pharmaceutical Products for which Benefits are described under the Prescription Drug Rider or 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.

Also note that some Prescription Drug Products require that you notify us in advance to determine whether the Prescription Drug Product meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

If you require certain 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 the Designated Pharmacy, you will be subject to the Non-Network Benefit for that Prescription Drug Product.

PHARMACY EXCLUSIONS

Exclusions from coverage listed in the Certificate apply also to this Rider [except any pre-existing condition exclusion in the Certificate is not applicable to this Rider]. In addition, the exclusions listed below apply.

Exclusions

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- [Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.]
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- 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.
- 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.
- 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.
- [Any product dispensed for the purpose of appetite suppression or weight loss.]
- A Pharmaceutical Product for which Benefits are provided in your Certificate. [This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.] [This exclusion does not apply to immunizations administered in a [Network] [,] [non-Network] [Network or non-Network] [or] [a Designated] Pharmacy.]
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging of Prescription Drug Products.
- Medications used for cosmetic purposes.
- 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.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- [Prescription Drug Products when prescribed to treat infertility.]
- [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.]
- [Treatment for toenail Onychomycosis (toenail fungus).]
- [Prescription Drug Products for smoking cessation.]
- [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.]
- [A Prescription Drug Product prescribed by a non-Network Physician or other non-Network provider.]
- [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]).] [Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.]
- [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-

YOUR BENEFITS

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.][This exclusion does not apply to over-the-counter drugs used for smoking cessation.]

- [New Prescription Drug Products and/or new dosage forms until the date they are assigned to a tier by our PDL Management Committee.]
- [Growth hormone therapy.] [Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).]
- [Any oral non-sedating antihistamine or antihistamine-decongestant combination.]
- [Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.]
- 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.
- [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.]
- [Prescription Drug Products when prescribed as sleep aids.]
- [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.]
- [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.]

Benefit Summary

Outpatient Prescription Drug

Arkansas

[Plan Description] -SHARED PHARMACY PLAN® -Plan [XX]

The new prescription drug plan chosen by your employer provides you with access to a comprehensive selection of prescription drugs. UnitedHealthcare's Shared Pharmacy Plan contributes a set dollar amount for the cost of each prescription. Your cost for covered prescription drugs will vary depending on the type of drug that you and your doctor select, the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product, the total cost of the prescription and the United Healthcare Shared Pharmacy Plan contribution. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to www.myuhc.com® or calling the Customer Care number on your ID card.

[Annual [Drug] Deductible – [Network] [and] [Non-Network]]

[Individual Deductible]	[No Annual Drug Deductible] [\$XX]
[Family Deductible]	[No Annual Drug Deductible] [\$XX]

[Annual Out-of-Pocket [Drug] Maximum – [Network] [and] [Non-Network]]

[Individual Out-of-Pocket Maximum]	[No Out-of-Pocket Drug Maximum] [\$XX]
[Family Out-of-Pocket Maximum]	[No Out-of-Pocket Drug Maximum] [\$XX] [The Annual Out-of-Pocket Drug Maximum includes the Annual Drug Deductible.]

Tier Level	Retail Up to 31-day supply	
	Network	[Non-Network]
Tier 1	Copayment: \$XX Maximum Per Drug Benefit: \$XX	Copayment: \$XX Maximum Per Drug Benefit: \$XX
Tier 2	Copayment: \$XX Maximum Per Drug Benefit: \$XX	Copayment: \$XX Maximum Per Drug Benefit: \$XX
Tier 3	Copayment: \$XX Maximum Per Drug Benefit: \$XX	Copayment: \$XX Maximum Per Drug Benefit: \$XX
[Tier 4]	[Copayment: \$XX] [Maximum Per Drug Benefit: \$XX]	[Copayment: \$XX] [Maximum Per Drug Benefit: \$XX]

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug Product expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

[Item #] [Rev. Date] [Plan Name]
[XXX-XXXX] [XX/XX] [XXXXXXXXXX]

UnitedHealthcare Insurance Company

YOUR BENEFITS

[*Mail Order Copayment]			
	[For up to a 31 day supply]	[For a 32-62 day supply]	[For a 63-90 day supply]
[Tier 1]	[Copayment: \$XX] [Maximum Per Drug Benefit: \$XX]	[Copayment: \$XX] [Maximum Per Drug Benefit: \$XX]	[Copayment: \$XX] [Maximum Per Drug Benefit: \$XX]
[Tier 2]	[Copayment: \$XX] [Maximum Per Drug Benefit: \$XX]	[Copayment: \$XX] [Maximum Per Drug Benefit: \$XX]	[Copayment: \$XX] [Maximum Per Drug Benefit: \$XX]
[Tier 3]	[Copayment: \$XX] [Maximum Per Drug Benefit: \$XX]	[Copayment: \$XX] [Maximum Per Drug Benefit: \$XX]	[Copayment: \$XX] [Maximum Per Drug Benefit: \$XX]
[Tier 4]	[Copayment: \$XX] [Maximum Per Drug Benefit: \$XX]	[Copayment: \$XX] [Maximum Per Drug Benefit: \$XX]	[Copayment: \$XX] [Maximum Per Drug Benefit: \$XX]

*Only certain Prescription Drug Products are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on the back of your ID card for more information.

[Note: If you purchase a Prescription Drug Product from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount we would have paid for the same Prescription Drug by a Network Pharmacy.]

Other Important Information about your Outpatient Prescription Drug Benefits

You are responsible for paying the lower of the applicable Copayment and/or Coinsurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment and/or Coinsurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Supply limits apply to Specialty Prescription Drug Products whether obtained at a retail pharmacy or through a mail order pharmacy.

Some Prescription Drug Products or Pharmaceutical Products for which Benefits are described under the Prescription Drug Rider or 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.

Also note that some Prescription Drug Products require that you notify us in advance to determine whether the Prescription Drug Product meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

If you require certain 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 the Designated Pharmacy, you will be subject to the Non-Network Benefit for that Prescription Drug Product.

Copayment: See first page for the amount you must pay per Prescription Order or Refill for a Prescription Drug Product at a pharmacy before we begin paying for that Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits. At a retail Network Pharmacy, you must pay the lower of the applicable Copayment or the retail Network Pharmacy's Usual and Customary Charge. At a mail order Pharmacy, you must pay the lower of the applicable Copayment or the mail order Pharmacy's Prescription Drug Cost.

Maximum Per Drug Benefit: See first page for the maximum amount we will pay after you have paid the applicable Copayment for any covered Prescription Order or Refill. You must pay the amount that exceeds the Maximum Per Drug Benefit for a Prescription Drug Product for up to the stated supply limit. However, this amount is limited by the Annual Out-of-Pocket Drug Maximum.

NOTE: Copayment and Maximum Per Drug Benefit amounts are per Prescription Order or Refill.

PHARMACY EXCLUSIONS

Exclusions from coverage listed in the Certificate apply also to this Rider [except any pre-existing condition exclusion in the Certificate is not applicable to this Rider]. In addition, the exclusions listed below apply.

Exclusions

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- [Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.]
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- 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.
- 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.
- 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.
- [Any product dispensed for the purpose of appetite suppression or weight loss.]
- A Pharmaceutical Product for which Benefits are provided in your Certificate. [This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.] [This exclusion does not apply to immunizations administered in a [Network] [,] [non-Network] [Network or non-Network] [or] [a Designated] Pharmacy.]
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging of Prescription Drug Products.
- Medications used for cosmetic purposes.
- 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.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products when prescribed to treat infertility.
- [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.]
- [Treatment for toenail Onychomycosis (toenail fungus).]
- [Prescription Drug Products for smoking cessation.]
- [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]).] [Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.]
- [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,

YOUR BENEFITS

and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.][This exclusion does not apply to over-the-counter drugs used for smoking cessation.]

- [New Prescription Drug Products and/or new dosage forms until the date they are assigned to a tier by our PDL Management Committee.]
- [Growth hormone therapy.] [Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).]
- [Any oral non-sedating antihistamine or antihistamine-decongestant combination.]
- [Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.]
- 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.
- [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.]
- [Prescription Drug Products when prescribed as sleep aids.]
- [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.]
- [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.]

SERFF Tracking Number: UHLC-126551161 State: Arkansas
 Filing Company: United HealthCare Insurance Company State Tracking Number: 45216
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: 2009 AR Federal Legislation Benefit Summary Filing
 Project Name/Number: /

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	04/01/2010
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Application	Approved-Closed	04/01/2010
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	04/01/2010
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Outline of Coverage	Approved-Closed	04/01/2010
Bypass Reason:	N/A		
Comments:			
Satisfied - Item:	Cover Letter	Approved-Closed	04/01/2010
Comments:			
Attachment:			
	INS Ben Sum Cover.pdf 3.19.10.pdf		

March 19, 2010,

Via U.S. Mail

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

NAIC: 79413 UnitedHealthcare Insurance Company

Form # BENSUM.GENRX.PLS.I.09.AR
BENSUM.RX.PLS.I.09.AR
BENSUMSHAREPLS.I.09.AR

Dear Ms. Minor,

On behalf of UnitedHealthcare Insurance Company, please accept this correspondence as a submission of the above referenced Benefit Summaries for the Arkansas Insurance Department's ("the Department") review. These forms support the 2009 AR INS Federal Form Filing which was approved by your office on October 30th, 2009.

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

Respectfully,

Ebony N. Terry
Compliance Analyst

Enclosure
ENT