

SERFF Tracking Number: UHLC-126667084 State: Arkansas  
Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 45904  
Company Tracking Number:  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: Prostate Cancer Screening  
Project Name/Number: /

## Filing at a Glance

Company: UnitedHealthcare of Arkansas, Inc.

Product Name: Prostate Cancer Screening

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: UHLC-126667084 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 45904

Co Tr Num:

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Author: Ebony Terry

Disposition Date: 06/17/2010

Date Submitted: 06/09/2010

Disposition Status: Approved-  
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type:

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 06/17/2010

Explanation for Other Group Market Type:

State Status Changed: 06/17/2010

Deemer Date:

Created By: Ebony Terry

Submitted By: Ebony Terry

Corresponding Filing Tracking Number:

PPACA: Pre-PPACA Submission

Filing Description:

See Cover Letter

## Company and Contact

### Filing Contact Information

Ebony Terry, Compliance Analyst

Ebony\_N\_Terry@uhc.com

800 King Farm Blvd.

240-632-8053 [Phone]

Suite 500

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Rockville, MD 20850

**Filing Company Information**

UnitedHealthcare of Arkansas, Inc.	CoCode: 95446	State of Domicile: Arkansas
Plaza West Building	Group Code:	Company Type: HMO
415 North McKinley Street, Suite 300	Group Name:	State ID Number:
Little Rock, AK 72205	FEIN Number: 63-1036819	
(952) 992-7428 ext. [Phone]		

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$300.00  
 Retaliatory? No  
 Fee Explanation: 6 forms X \$50.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare of Arkansas, Inc.	\$300.00	06/09/2010	37104242

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/17/2010	06/17/2010

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Disposition Date: 06/17/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Supporting Document</b>	PPACA Uniform Compliance Summary	Approved-Closed	Yes
<b>Supporting Document</b>	Cover Letter	Approved-Closed	Yes
<b>Form</b>	Prst.CS Amendment	Approved-Closed	Yes
<b>Form</b>	Prst. CS Amendment	Approved-Closed	Yes
<b>Form</b>	Prst. CS Amendment	Approved-Closed	Yes
<b>Form</b>	Prst. CS Amendment	Approved-Closed	Yes
<b>Form</b>	Prst. CS Amendment	Approved-Closed	Yes
<b>Form</b>	Prst. CS Amendment	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 06/17/2010	[C][S]AMD.H.04.AR(R ev. 1.2010)	Certificate Amendmen t, Insert	Prst.CS Amendment	Initial			[C][S]AMD.H.04.AR(Rev. 1.2010).pdf
Approved-Closed 06/17/2010	[CP][SP]A MD.H.04.A R(Rev 1.2010)	Certificate Amendmen t, Insert	Prst. CS Amendment	Initial			[CP][SP]AMD.H.04.AR(Rev 1.2010).pdf
Approved-Closed 06/17/2010	CHCAMD.H.02.AR (Rev. 1.2010)	Certificate Amendmen t, Insert	Prst. CS Amendment	Initial			CHCAMD.H.02.AR (Rev. 1.2010).pdf
Approved-Closed 06/17/2010	CHCPLSA MD.H.02.A R (Rev. 1.2010)	Certificate Amendmen t, Insert	Prst. CS Amendment	Initial			CHCPLSAMD.H.02.AR (Rev. 1.2010).pdf
Approved-Closed 06/17/2010	SEL.AMD.H.02.AR(R ev. 1.2010)	Certificate Amendmen t, Insert	Prst. CS Amendment	Initial			SEL.AMD.H.02.AR(Rev. 1.2010).pdf
Approved-	SELPLSAM	Certificate	Prst. CS Amendment	Initial			SELPLSAMD.

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# 2004 Amendment to the Certificate of Coverage

*The Certificate of Coverage is modified as described in this Amendment.*

## Section 1: What's Covered--Benefits

**Product Design [Para]** Include when [United Access] [First Dollar Coverage] Payments is purchased.

***[(Section 1: What's Covered--Benefits) is expanded to include the following:***

**Product Design [Para]** [United Access] [First Dollar Coverage] are bracketed to allow for a change in the product name.

**Group [Para]** Select one of the following three initial paragraphs (#1, #2, or #3) and delete the other two. The last two paragraphs in this Section will always be included.

### **[United Access][First Dollar Coverage]**

**Group [Para]** [#1] Include this paragraph if, prior to having to meet the Annual Deductible, [United Access][First Dollar Coverage] pays 100% of Eligible Expenses. Delete the paragraph reference [#1].

**Group [text]** <sup>1</sup>Include if [United Access][First Dollar Coverage] is limited per family as well as per Covered Person.

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

**[[#1] We will pay \$[50 - 2,000] per Covered Person in a single [calendar] [Policy] year for Covered Health Services received from a Network provider before you are responsible for meeting the Annual Deductible or for paying Copayments stated in the Certificate of Coverage. [<sup>1</sup>The total amount of [United Access] [First Dollar Coverage] payments is further limited to \$[100 - 6,000] in a single [calendar] [Policy] year for all Covered Persons in a family.] If Benefits are provided through an outpatient prescription drug Rider, such Benefits are not included in [United Access] [First Dollar Coverage] payments.]**

**Group [Para]** [#2]Include this paragraph if, prior to having to meet the Annual Deductible, [United Access][First Dollar Coverage] applies, but Copayments (both flat dollar and percentage Copayments) are required. Delete the paragraph reference [#2].

**Group [text]** <sup>1</sup>Include if [United Access][First Dollar Coverage] is limited per family as well as per Covered Person.

*[To continue reading, go to left column on next page.]*

**[#2]** We will pay \$[50 - 2,000] per Covered Person in a single [calendar] [Policy] year for Covered Health Services received from a Network provider before you are responsible for meeting the Annual Deductible stated in the Certificate of Coverage. <sup>1</sup>The total amount of [United Access] [First Dollar Coverage] payments is further limited to \$[100 - 6,000] in a single [calendar] [Policy] year for all Covered Persons in a family.] You are still required to pay the applicable Copayments stated in the Benefit Information table in (Section 1: What's Covered--Benefits). If Benefits are provided through an outpatient prescription drug Rider, such Benefits are not included in [United Access] [First Dollar Coverage] payments.]

**Group [Para]** <sup>[#3]</sup>Include this paragraph if, prior to having to meet the Annual Deductible, [United Access][First Dollar Coverage] pays 100% of Eligible Expenses for services subject to percentage Copayments, but flat dollar Copayments are required. Delete the paragraph reference [#3].

**Group [text]** <sup>1</sup>Include if [United Access][First Dollar Coverage] is limited per family as well as per Covered Person.

**[#3]** We will pay \$[50 - 2,000] per Covered Person in a single [calendar] [Policy] year for Covered Health Services received from a Network provider before you are responsible for meeting the Annual Deductible or for paying Copayments that are charged as a percentage of Eligible Expenses stated in the Certificate of Coverage. <sup>1</sup>The total amount of [United Access] [First Dollar Coverage] payments is further limited to \$[100 - 6,000] in a single [calendar] [Policy] year for all Covered Persons in a family.] You are still required to pay the applicable flat dollar Copayments stated in the Benefit Information table in (Section 1: What's Covered--Benefits). If Benefits are provided through an outpatient prescription drug Rider, such Benefits are not included in [United Access] [First Dollar Coverage] payments.]

**Group [text]** <sup>1</sup>Include if Maximum Policy Benefit does not include [United Access][First Dollar Coverage] payments.

The amount we pay in [United Access] [First Dollar Coverage] payments is <sup>1</sup>not included in any Maximum Policy Benefit stated in the Certificate of Coverage.

**Group [text]** <sup>1</sup>Include if [United Access][First Dollar Coverage] is limited per family as well as per Covered Person.

**Group [text]** <sup>2</sup>Include if carry over does not apply to [United Access][First Dollar Coverage].

**Group [text]** <sup>3</sup>Include if the carry over amount is limited over multiple years of coverage. <sup>3-A</sup>Include when carry over amount is limited per person. <sup>3-B</sup>Include when carry over amount is limited per family. <sup>3-C</sup>Include when carry over amount is limited per person/per family.

If you <sup>1</sup>or all Covered Persons in your family] do not use the total amount of [United Access] [First Dollar Coverage] payments available for Covered Health Services in a single [calendar] [Policy] year, the remaining amount of [United Access] [First Dollar Coverage] payments will <sup>2</sup>not be carried over to the next [calendar] [Policy] year. <sup>3</sup>This carry-over amount shall not exceed <sup>3-A</sup>\$[100 - \$4,000] per Covered Person] <sup>3-C</sup>and] <sup>3-B</sup>\$[200 - \$12,000] for all Covered Persons in a family].]

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

*[To continue reading, go to left column on next page.]*

*[The Annual Deductible provision in the Payment Information table in (Section 1: What's Covered--Benefits) is replaced with the following:*

## Payment Information

Payment Term	Description	Amounts
<b>Annual Deductible</b>	Group [text] <sup>1</sup> Include when Annual Deductible provision applies.	Group [Para] Include when separate individual and family Annual Deductible provisions apply:
	Group [text] <sup>2</sup> Include when an Outpatient Prescription Drug Rider is sold and the Annual Deductible applies to any combination of medical and RX benefits.	Group [text] <sup>1</sup> Insert appropriate amounts for individual and family Annual Deductible <p>[For single coverage, the Annual Deductible is \$[<sup>1</sup>0 – 7,500] per Covered Person per [calendar] [Policy] year.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[<sup>1</sup>0 – 22,500] per [calendar] [Policy] year. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p>
	The amount you pay for Covered Health Services before you are eligible to receive Benefits. [ <sup>1</sup> For a complete definition of Annual Deductible, see (Section 10: Glossary of Defined Terms).] [ <sup>2</sup> The Annual Deductible applies to all Covered Health Services under the Policy, including Covered Health Services provided under the Outpatient Prescription Drug Rider.]	Group [Para] Include when individual with family maximum Annual Deductible provision applies: Group [text] <sup>1</sup> Insert appropriate amounts for individual and family Annual Deductible <p>[\$[<sup>1</sup>0 - 7,500] per Covered Person per [calendar] [Policy] year, not to exceed \$[<sup>1</sup>0 - 22,500] for all Covered Persons in a family.]</p> Group [Para] Include when Annual Deductible provision does not apply. <p>[No Annual Deductible]</p>

*[The Out-of-Pocket Maximum provision in the Payment Information table in (Section 1: What's Covered--Benefits) is replaced with the following:*

## Payment Information

Payment Term	Description	Amounts
<b>Out-of-</b>	Group [text] <sup>1</sup> Include when OOPM provision applies.	Group [Para] Include when OOPM provision applies separately to individual and to family.
	Group [text] <sup>2</sup> Include when an Outpatient	Group [text] <sup>1</sup> Insert appropriate amounts for individual and family OOPM.

Payment Term	Description	Amounts
<b>Pocket Maximum</b>	<p>Prescription Drug Rider is sold and the Out-of-Pocket Maximum applies to any combination of medical and RX benefits.</p> <p>The maximum you pay, out of your pocket, in a [calendar][Policy] year for Copayments. <sup>1</sup>For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms).] <sup>2</sup>The Out-of-Pocket Maximum applies to all Covered Health Services under the Policy, including Covered Health Services provided under the Outpatient Prescription Drug Rider.]</p>	<p>[For single coverage, the Out-of-Pocket Maximum is \$<sup>1</sup>0 – 10,000] per Covered Person per [calendar] [Policy] year.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$<sup>1</sup>0 – 30,000] per [calendar] [Policy] year.]</p> <p>Group [Para] Include when OOPM provision applies to individual with family maximum.                      Group [text] <sup>1</sup>Insert appropriate amounts for individual and family                      [\$<sup>1</sup>0 - 10,000] per Covered Person per [calendar][Policy] year, not to exceed \$<sup>1</sup>0 - 30,000] for all Covered Persons in a family.]</p> <p>Group [Para] Include when OOPM and Annual Deductible provisions apply.                      Group [text] <sup>2</sup>Include if Annual Deductible does not apply to OOPM.                      [The Out-of-Pocket Maximum does <sup>2</sup>not] include the Annual Deductible.]</p> <p>Group [text] Include if OOPM provision does not apply.                      [No Out-of-Pocket Maximum]]</p>

[Emergency Health Services described in (Section 1: What's Covered--Benefits) is replaced with the following:

## Benefit Information

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<b>Emergency Health Services</b> Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an	[\$0 - 250] per visit][0 - 50]%	[Yes] [No]	[Yes][No] [Not

outpatient basis at a Hospital or Alternate Facility. [No Copayment] Applicable]

You will find more information about Benefits for Emergency Health Services in (Section 3: Obtaining Benefits).

**[Outpatient Surgery, Diagnostic and Therapeutic Services described in (Section 1: What's Covered--Benefits) is replaced with the following:**

## Benefit Information

Description of Covered Health Service

Your Copayment Amount

% Copayments are based on a percent of Eligible Expenses

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

**[Do You Need to Meet Annual Deductible?]**

## Outpatient Surgery, Diagnostic and Therapeutic Services

### Outpatient Surgery

Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Administrative [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.

Administrative [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.

Benefits under this section include only the facility charge and the charge for <sup>1</sup>required Hospital-based professional services, supplies and equipment. Benefits for the surgeons fees <sup>2</sup>and facility-based Physician's fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services*.

[\$[0 - 1,000] per surgical procedure] [[0 - 50]%]

[No Copayment] <sup>1</sup>Your

Copayment will range between \$[0 - 3,000] per surgical procedure]

[Yes][No]

[Yes][No]   
 [Not Applicable]

Description of  
Covered Health Service

Your Copayment  
Amount

% Copayments are  
based on a percent of  
Eligible Expenses

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

[Do You Need  
to Meet Annual  
Deductible?]

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

Group [text] <sup>1</sup>Include if Benefit design includes a variable Copayment depending upon the Network provider selected.

**[<sup>1</sup> The Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]**

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b><i>Outpatient Diagnostic Services</i></b> Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:</p> <ul style="list-style-type: none"> <li>• Lab and radiology/X-ray.</li> <li>• Mammography testing.</li> </ul> <p>Administrative [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.</p> <p>Administrative [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.</p> <p>Benefits under this section include the facility charge, <sup>2</sup>and] the charge for required services, supplies and equipment<sup>1</sup>, and all related professional fees]. <sup>2</sup>Benefits for facility-based Physician's fees related to these services are described under <i>Professional Fees for Surgical and Medical Services.</i></p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.</p> <p>This section does not include Benefits for CT scans, PET scans, MRIs, or nuclear medicine, which are described immediately below.</p>	<p><b><i>For preventive diagnostic services:</i></b>                      [0 - 1,000] per test                      [[0 - 50]%]                      [No Copayment]</p>	<p>[Yes][No]</p>	<p>[Yes][No]                      [Not Applicable]</p>
	<p><b><i>For preventive mammography testing:</i></b>                      [0 - 1,000] per test                      [[0 - 50]%]                      [No Copayment]</p>	<p>[Yes][No]</p>	<p>[Yes][No]                      [Not Applicable]</p>
	<p><b><i>For Sickness and Injury-related diagnostic services:</i></b>                      [0 - 1,000] per test                      [[0 - 50]%]                      [No Copayment]</p>	<p>[Yes][No]</p>	<p>[Yes][No]                      [Not Applicable]</p>

UnitedHealthcare of Arkansas, Inc.

Description of Covered Health Service

Your Copayment Amount

% Copayments are based on a percent of Eligible Expenses

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

[Do You Need to Meet Annual Deductible?]



Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b><i>Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine</i></b></p> <p>Covered Health Services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>Administrative [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.</p> <p>Administrative [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.</p> <p>Benefits under this section include the facility charge, <sup>2</sup>and] the charge for required services, supplies and equipment<sup>1</sup>, and all related professional fees]. <sup>2</sup>Benefits for facility-based Physician's fees related to these services are described under <i>Professional Fees for Surgical and Medical Services.</i></p> <p>Group [text] <sup>1</sup>Include if Benefit design includes a variable Copayment depending upon the Network provider selected.</p> <p><b><i>[The Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]</i></b></p>	<p>[\$[0 - 1,000] per test [[0 - 50]%] [No Copayment] [<sup>1</sup>Your Copayment will range between \$[0 - 3,000] per test]</p>	<p>[Yes][No]</p>	<p>[Yes][No] [Not Applicable]</p>
<p><b><i>Outpatient Therapeutic Treatments</i></b></p> <p>Covered Health Services for therapeutic treatments received on an</p>	<p>[\$[0 - 1,000] per</p>	<p>[Yes][No]</p>	<p>[Yes][No]</p>

Description of Covered Health Service	Your Copayment Amount	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.	treatment] [[0 - 50]%) [No Copayment]		[Not Applicable]
<p>Administrative [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.</p> <p>Administrative [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.</p> <p>Benefits under this section include the facility charge, <sup>2</sup>and] the charge for required services, supplies and equipment<sup>1</sup>, and all related professional fees]. <sup>2</sup>Benefits for facility-based Physician's fees related to these services are described under <i>Professional Fees for Surgical and Medical Services.</i></p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.</p>			

**[Physician's Office Services described in (Section 1: What's Covered--Benefits) is replaced with the following:**

### Benefit Information

Description of Covered Health Service	Your Copayment Amount	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>Group [text] <sup>1</sup>Include when a separate Copayment for a Specialist Physician office visit applies.</p>			

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>Physician's Office Services</b></p> <p>Covered Health Services for preventive medical care.</p> <p>Preventive medical care includes:</p> <ul style="list-style-type: none"> <li>Voluntary family planning.</li> </ul>	<p>[\$[0 - 75] per visit][[0 - 50]%] [<sup>1</sup>, except that the Copayment for a Network Specialist Physician office visit is[\$[0 - 100]][[0 - 50]%]]</p> <p>[No Copayment applies when no Physician charge is assessed.]</p> <p>[No Copayment]<sup>2</sup>Your Copayment will range between \$[0 - 75] per visit]</p>	<p>[Yes][No]</p>	<p>[Yes. Prostate Cancer Screenings not subject to Annual Deductible.]</p> <p>[No][Not Applicable]</p>
<p><b>State Mandate</b></p>	<ul style="list-style-type: none"> <li>Well-baby and well-child care. Care shall include 20 visits at approximately the following age intervals: Birth, 2 Weeks, 2 Months, 4 Months, 6 Months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years and 18 years.</li> <li>Routine physical examinations.</li> <li>Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See <i>Eye Examinations</i> earlier in this section.)</li> <li>Immunizations. Please Note: No Copayment, Coinsurance or Deductible will be applicable to children's immunization services.</li> <li>Prostate Cancer Screenings provided at minimum one (1) screening per [calendar][Policy] year for any male Covered Person forty (40) years of age or older.</li> </ul>		
<p><b>Product Design [Para]</b> Include if Benefits for preventive care are limited.</p>	<p>[Benefits for preventive medical care are limited to [1 - 5] visit[s] per</p>		

Description of Covered Health Service	Your Copayment Amount	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>Covered Person per [calendar] [Policy] year. [This limit does not apply to Enrolled Dependent children under the age of 19.]</p>	<p>% Copayments are based on a percent of Eligible Expenses</p>		
<p><b>Covered Health Services for the diagnosis and treatment of a Sickness or Injury.</b></p>	<p>[\$[0 - 75] per visit [[0 - 50]%] <sup>1</sup>, except that the Copayment for a Network Specialist Physician office visit is[\$[0 - 100]] [[0 - 50]%] [No Copayment applies when no Physician charge is assessed.] [No Copayment] <sup>2</sup>Your Copayment will range between \$[0 - 75] per visit]</p>	<p>[Yes][No]</p>	<p>[Yes][No] [Not Applicable]</p>
<p>Group [text] <sup>2</sup>Include if Benefit design includes a variable Copayment for Network Benefits depending upon the Network provider selected.</p> <p><sup>2</sup><i>The Copayments that apply to Physician's Office Services are based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.</i></p>			

*[Professional Fees for Surgical and Medical Services described in (Section 1: What's Covered--Benefits) is replaced with the following:*

## Benefit Information

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>Professional Fees for Surgical and Medical Services</b></p> <p>Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.</p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> above.</p>	<p>[[0 – 50]%] [No Copayment] [<sup>1</sup>Your Copayment will range between [0 - 50]%]</p>	<p>[Yes][No]</p>	<p>[Yes][No] [Not Applicable]</p>

Group [text] <sup>1</sup>Include if Benefit design includes a variable Copayment for Network Benefits depending upon the Network provider selected.

**[<sup>1</sup> The Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]**

## [Section 10: Glossary of Defined Terms]

**[The definition of Annual Deductible is replaced with the following:**

Group [Para]	Include if group chooses a plan design with an Annual Deductible provision.
Group [text]	<sup>1</sup> Include when an Outpatient Prescription Drug Rider is sold and the Annual Deductible applies to any combination of medical and RX benefits.

**[Annual Deductible** - the amount you must pay for Covered Health Services in a [calendar] [Policy] year before we will begin paying for Benefits in that [calendar] [Policy] year. [<sup>1</sup>The Annual Deductible applies to all Covered Health Services under the Policy, including Covered Health Services provided under the Outpatient Prescription Drug Rider.]

Group [Para]	Include paragraph only if the carry-over provision applies.
[Any amount you pay for medical expenses in the last three months of the previous [calendar] [Policy] 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.]]]	

**[The definition of Out-of-Pocket Maximum is replaced with the following:**

Group [Para]	Include if group chooses a plan design that includes an Out-of-Pocket-Maximum provision.
Group [text]	<sup>1</sup> Include if Annual Deductible provision applies and if the OOPM includes the Annual Deductible.
Group [text]	<sup>2</sup> Include when an Outpatient Prescription Drug Rider is sold and the Out-of-Pocket Maximum applies to any combination of medical and RX benefits.
Group [text]	<sup>3</sup> Delete if benefit plan design applies all Copayments in Section 1 to the OOPM.

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

**[Out-of-Pocket Maximum** - the maximum amount of [<sup>1</sup>Annual Deductible and] Copayments you pay every [calendar] [Policy] year. Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that [calendar] [Policy] year. [<sup>2</sup>The Out-of-Pocket Maximum applies to all Covered Health Services under the Policy, including Covered Health Services provided under the Outpatient Prescription Drug Rider.] [<sup>3</sup>Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in (Section 1: What's Covered--Benefits) and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.]

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services.
- |              |                                                                                                                                                 |
|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------|
| Group [Para] | Exclude when an Outpatient Prescription drug Rider is sold and the Out-of-Pocket Maximum applies to any combination of medical and Rx benefits. |
|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------|
- [Copayments for Covered Health Services available through any Outpatient Prescription Drug Rider.]
  - Any Copayments for Covered Health Services in (Section 1: What's Covered--Benefits) that do not apply to the Out-of-Pocket Maximum.
- |              |                                                                                                  |
|--------------|--------------------------------------------------------------------------------------------------|
| Group [text] | <sup>2</sup> Include if an Annual Deductible provision applies, but is not included in the OOPM. |
|--------------|--------------------------------------------------------------------------------------------------|
- [<sup>2</sup>The Annual Deductible.]

Even when the Out-of-Pocket Maximum has been reached, you will

*[To continue reading, go to left column on next page.]*

still be required to pay:

- Any charges for non-Covered Health Services.

**Group [Para]** Exclude when an Outpatient Prescription drug Rider is sold and the Out-of-Pocket Maximum applies to any combination of medical and Rx benefits.

- [Copayments for Covered Health Services available through any Outpatient Prescription Drug Rider.]
- Copayments for Covered Health Services in (Section 1: What's Covered--Benefits) that are subject to Copayments that do not apply to the Out-of-Pocket Maximum.]]

***[The definition of Specialist Physician is added:***

**Group [Para]** Include when a separate Copayment for a Specialist Physician office visit applies.

***[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.]]

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(Name and Title)

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# 2004 Amendment to the Certificate of Coverage

*The Certificate of Coverage is modified as described in this Amendment.*

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## Section 1: What's Covered--Benefits

**Product Design [Para]** Include when [United Access] [First Dollar Coverage] Payments is purchased.

***[(Section 1: What's Covered--Benefits) is expanded to include the following:***

**Product Design [Para]** [United Access] [First Dollar Coverage] are bracketed to allow for a change in the product name.

**Group [Para]** Select one of the following three initial paragraphs (#1, #2, or #3) and delete the other two. The last two paragraphs in this Section will always be included.

### **[United Access][First Dollar Coverage]**

**Group [Para]** [#1] Include this paragraph if, prior to having to meet the Annual Deductible, [United Access][First Dollar Coverage] pays 100% of Eligible Expenses. Delete the paragraph reference [#1].

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

**Group [text]** <sup>1</sup>Include if [United Access][First Dollar Coverage] applies to both Network and Non-Network Benefits.

**Group [text]** <sup>2</sup>include if [United Access][First Dollar Coverage] is limited per family as well as per Covered Person.

**[[#1] We will pay \$[50 - 2,000] per Covered Person in a single [calendar] [Policy] year for Covered Health Services received from a Network [<sup>1</sup>or non-Network] provider before you are responsible for meeting the Annual Deductible or for paying Copayments stated in the Certificate of Coverage. [<sup>2</sup>The total amount of [United Access] [First Dollar Coverage] payments is further limited to \$[100 - 6,000] in a single [calendar] [Policy] year for all Covered Persons in a family.] If Benefits are provided through an outpatient prescription drug Rider, such Benefits are not included in [United Access] [First Dollar Coverage] payments.]**

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Group [Para]	[#2] Include this paragraph if, prior to having to meet the Annual Deductible, [United Access][First Dollar Coverage] applies, but Copayments (both flat dollar and percentage Copayments) are required. Delete the paragraph reference [#2].
Group [text]	<sup>1</sup> Include if [United Access][First Dollar Coverage] applies to both Network and Non-Network Benefits.
Group [text]	<sup>2</sup> Include if [United Access][First Dollar Coverage] is limited per family as well as per Covered Person.

**[[#2] We will pay \$[50 - 2,000] per Covered Person in a single [calendar] [Policy] year for Covered Health Services received from a Network [<sup>1</sup>or non-Network] provider before you are responsible for meeting the Annual Deductible stated in the Certificate of Coverage. [<sup>2</sup>The total amount of [United Access] [First Dollar Coverage] payments is further limited to \$[100 - 6,000] in a single [calendar] [Policy] year for all Covered Persons in a family.] You are still required to pay the applicable Copayments stated in the Benefit Information table in (Section 1: What’s Covered--Benefits). If Benefits are provided through an outpatient prescription drug Rider, such Benefits are not included in [United Access] [First Dollar Coverage] payments.]**

Group [Para]	[#3] Include this paragraph if, prior to having to meet the Annual Deductible, [United Access][First Dollar Coverage] pays 100% of Eligible Expenses for services subject to percentage Copayments, but flat dollar Copayments are required. Delete the paragraph reference [#3].
Group [text]	<sup>1</sup> Include if [United Access][First Dollar Coverage] applies to both Network and Non-Network Benefits.
Group [text]	<sup>2</sup> Include if [United Access][First Dollar Coverage] is limited per family as well as per Covered Person.

**[[#3] We will pay \$[50 - 2,000] per Covered Person in a single [calendar] [Policy] year for Covered Health Services received from a Network [<sup>1</sup>or non-Network] provider before you are responsible for meeting the Annual Deductible or for paying Copayments that are charged as a percentage of Eligible Expenses stated in the Certificate of Coverage. [<sup>2</sup>The total amount of [United Access] [First Dollar Coverage] payments is further limited to \$[100 - 6,000] in a single [calendar] [Policy] year for all Covered Persons in a family.] You are still required to pay the applicable flat dollar Copayments stated in the Benefit Information table in (Section 1: What’s Covered--Benefits). If Benefits are provided through an outpatient prescription drug Rider, such Benefits are not included in [United Access] [First Dollar Coverage] payments.]**

Group [text]	<sup>1</sup> Include if Maximum Policy Benefit does not include [United Access][First Dollar Coverage] payments.
--------------	------------------------------------------------------------------------------------------------------------------

The amount we pay in [United Access] [First Dollar Coverage] payments is [<sup>1</sup>not] included in any Maximum Policy Benefit stated in the Certificate of Coverage.

Group [text]	<sup>1</sup> Include if [United Access][First Dollar Coverage] is limited per family as well as per Covered Person.
Group [text]	<sup>2</sup> Include if carry over does not apply to [United Access][First Dollar Coverage].
Group [text]	<sup>3</sup> Include if the carry over amount is limited over multiple years of coverage. <sup>3-A</sup> Include when carry over amount is limited per person. <sup>3-B</sup> Include when carry over amount is limited per family. <sup>3-C</sup> Include when carry over amount is limited per person/per family.

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If you [<sup>1</sup>or all Covered Persons in your family] do not use the total amount of [United Access] [First Dollar Coverage] payments available for Covered Health Services in a single [calendar] [Policy] year, the remaining amount of [United Access] [First Dollar Coverage] payments will [<sup>2</sup>not] be carried over to the next [calendar] [Policy] year. [<sup>3</sup>This carry-over amount shall not exceed [<sup>3-A</sup>\$[100 - \$4,000] per Covered Person] [<sup>3-C</sup>and] [<sup>3-B</sup>\$[200 - \$12,000] for all Covered Persons in a family].]

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*[To continue reading, go to left column on next page.]*

*[The Annual Deductible provision in the Payment Information table in (Section 1: What's Covered--Benefits) is replaced with the following:*

## Payment Information

Payment Term	Description	Amounts
<b>Annual Deductible</b>	Group [text] <sup>1</sup> Include when Annual Deductible provision applies, but only to Non-Network Benefits.	Group [Para] Include when Annual Deductible provision applies separately to Network and Non-Network Benefits <b><u>Network</u></b>
	Group [text] <sup>2</sup> Include when Annual Deductible provision applies.	Group [Para] Include when separate individual and family Annual Deductible provisions apply:
	Group [text] <sup>3</sup> Include when an Outpatient Prescription Drug Rider is sold and the Annual Deductible applies to any combination of medical and RX benefits.	Group [text] <sup>1</sup> Insert appropriate amounts for individual and family Annual Deductible [For single coverage, the Annual Deductible is \$ <sup>1</sup> 0 – 7,500] per Covered Person per [calendar] [Policy] year.
	The amount you pay for Covered Health Services before you are eligible to receive <sup>1</sup> [Non-Network] Benefits. <sup>2</sup> For a complete definition of Annual Deductible, see (Section 10: Glossary of Defined Terms).] <sup>3</sup> The Annual Deductible applies to all Covered Health Services under the Policy, including Covered Health Services provided under the Outpatient Prescription Drug Rider.]	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 \$ <sup>1</sup> 0 – 22,500] per [calendar] [Policy] year. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]
		Group [Para] Include when individual with family maximum Annual Deductible provision applies:
		Group [text] <sup>1</sup> Insert appropriate amounts for individual and family Annual Deductible [\$ <sup>1</sup> 0 - 7,500] per Covered Person per [calendar] [Policy] year, not to exceed \$ <sup>1</sup> 0 - 22,500] for all Covered Persons in a family.]
		Group [Para] Include when Annual Deductible provision does not apply to Network Benefits. [No Annual Deductible]
		<b><u>Non-Network</u></b>
		Group [Para] Include when separate individual and family Annual Deductible provisions apply:
		Group [text] <sup>1</sup> Insert appropriate amounts for individual and family Annual Deductible [For single coverage, the Annual Deductible is \$ <sup>1</sup> 0 – 7,500] per Covered Person per [calendar] [Policy] year.

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Payment Term	Description	Amounts
		<p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[<sup>1</sup>0 – 22,500] per [calendar] [Policy] year. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p>
	Group [Para]	Include when individual with family maximum Annual Deductible provision applies:
	Group [text]	<sup>1</sup> Insert appropriate amounts for individual and family Annual Deductible
		[ <sup>1</sup> \$[ <sup>1</sup> 0 - 7,500] per Covered Person per [calendar] [Policy] year, not to exceed \$[ <sup>1</sup> 0 - 22,500] for all Covered Persons in a family.]
	Group [Para]	Include when Annual Deductible provision does not apply to Non-Network Benefits. <b>[No Annual Deductible]]</b>
	Group [Para]	Include when Annual Deductible provision applies to any combination of Network and Non-Network Benefits <b>[<u>Network and Non-Network</u>]</b>
	Group [Para]	Include when separate individual and family Annual Deductible provisions apply:
	Group [text]	<sup>1</sup> Insert appropriate amounts for individual and family Annual Deductible
		[For single coverage, the Annual Deductible is \$[ <sup>1</sup> 0 – 7,500] per Covered Person per [calendar] [Policy] year.
		<p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[<sup>1</sup>0 – 22,500] per [calendar] [Policy] year. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p>
	Group [Para]	Include when individual with family maximum Annual Deductible provision applies:
	Group [text]	<sup>1</sup> Insert appropriate amounts for individual and family Annual Deductible
		[ <sup>1</sup> \$[ <sup>1</sup> 0 - 7,500] per Covered Person per [calendar] [Policy] year, not to exceed \$[ <sup>1</sup> 0 - 22,500] for all Covered Persons in a family.]]]

*[The Out-of-Pocket Maximum provision in the Payment Information table in (Section 1: What's Covered--Benefits) is replaced with the following:*

## Payment Information

Payment Term	Description	Amounts
<p><b>Out-of-Pocket Maximum</b></p> <p>The maximum you pay, out of your pocket, in a [calendar][Policy] year for Copayments. <sup>1</sup>For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms).] <sup>2</sup>The Out-of-Pocket Maximum applies to all Covered Health Services under the Policy, including Covered Health Services provided under the Outpatient Prescription Drug Rider.]</p>	Group [text] <sup>1</sup> Include when OOPM provision applies.	Group [Para] Include when OOPM provision applies separately to Network and non-Network Benefits. <b>[Network]</b>
	Group [text] <sup>2</sup> Include when an Outpatient Prescription Drug Rider is sold and the Out-of-Pocket Maximum applies to any combination of medical and RX benefits.	Group [Para] Include when OOPM provision applies separately to individual and to family. Group [text] <sup>1</sup> Insert appropriate amounts for individual and family OOPM. <b>[For single coverage, the Out-of-Pocket Maximum is \$<sup>1</sup>0 – 10,000] per Covered Person per [calendar] [Policy] year.</b>
		<b>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 \$<sup>1</sup>0 – 30,000] per [calendar] [Policy] year.]</b>
		Group [Para] Include when OOPM provision applies to individual with family maximum. Group [text] <sup>1</sup> Insert appropriate amounts for individual and family <b>[\$<sup>1</sup>0 - 10,000] per Covered Person per [calendar][Policy] year, not to exceed \$<sup>1</sup>0 - 30,000] for all Covered Persons in a family.]</b>
		Group [Para] Include when OOPM and Annual Deductible provisions apply for Network Benefits. Group [text] <sup>2</sup> include if Annual Deductible does not apply to OOPM. <b>[The Out-of-Pocket Maximum does <sup>2</sup>not] include the Annual Deductible.]</b>
		Group [text] Include if OOPM provision does not apply to Network Benefits. <b>[No Out-of-Pocket Maximum]</b>
		<b><u>Non-Network</u></b>
		Group [Para] Include when OOPM provision applies separately to individual and to family. Group [text] <sup>1</sup> Insert appropriate amounts for individual and family OOPM. <b>[For single coverage, the Out-of-Pocket Maximum is \$<sup>1</sup>0 – 10,000] per</b>

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Payment Term	Description	Amounts
		Covered Person per [calendar] [Policy] year.
		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 \$ <sup>[1]</sup> 0 – 30,000 per [calendar] [Policy] year.]
	Group [Para]	Include when OOPM provision applies to individual with family maximum.
	Group [text]	<sup>1</sup> Insert appropriate amounts for individual and family [\$ <sup>[1]</sup> 0 - 10,000] per Covered Person per [calendar][Policy] year, not to exceed \$ <sup>[1]</sup> 0 - 30,000 for all Covered Persons in a family.]
	Group [Para]	Include when OOPM and Annual Deductible provisions apply for Non-Network Benefits.
	Group [text]	<sup>2</sup> Include if Annual Deductible does not apply to OOPM. [The Out-of-Pocket Maximum does <sup>[2]</sup> not include the Annual Deductible.]
	Group [text]	Include if OOPM provision does not apply to Non-Network Benefits. [No Out-of-Pocket Maximum]]
	Group [Para]	Include when OOPM provision applies to any combination of Network and Non-Network Benefits. <b><u>[Network and Non-Network]</u></b>
	Group [Para]	Include when OOPM provision applies separately to individual and to family.
	Group [text]	<sup>1</sup> Insert appropriate amounts for individual and family OOPM. [For single coverage, the Out-of-Pocket Maximum is \$ <sup>[1]</sup> 0 – 10,000] per Covered Person per [calendar] [Policy] year.
		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 \$ <sup>[1]</sup> 0 – 30,000 per [calendar] [Policy] year.]
	Group [Para]	Include when OOPM provision applies to individual with family maximum.
	Group [text]	<sup>1</sup> Insert appropriate amounts for individual and family

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Payment Term	Description	Amounts
		<p>[\$<sup>1</sup>0 - 10,000] per Covered Person per [calendar][Policy] year, not to exceed \$<sup>1</sup>0 - 30,000] for all Covered Persons in a family.]</p> <p>Group [Para] Include when OOPM and Annual Deductible provisions apply. Group [text] <sup>2</sup>Include if Annual Deductible does not apply to OOPM.</p> <p>[The Out-of-Pocket Maximum does [<sup>2</sup>not] include the Annual Deductible.]]</p>

*[Emergency Health Services described in (Section 1: What's Covered--Benefits) is replaced with the following:*

## Benefit Information

Description of Covered Health Service	Must You Notify Us?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>Emergency Health Services</b></p> <p>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.</p> <p>You will find more information about Benefits for Emergency Health Services in (Section 3: Description of Network and Non-Network Benefits).</p> <p style="text-align: center;"><b>Notify Us</b></p> <p>To ensure prompt and accurate payment of your claim as a Network Benefit, notify us within two business days or as soon as possible after you receive outpatient Emergency Health Services at a non-Network Hospital or Alternate Facility.</p> <p>Please remember that if you are admitted to a non-Network</p>	<p><u>Network</u></p> <p>No</p> <p><u>Non-Network</u></p> <p>Yes, but only for an Inpatient Stay</p>	<p>[\$[0 - 250] per visit][[0 - 50]%] [No Copayment]</p> <p>Same as Network</p>	<p>[Yes] [No]</p> <p>[Same as Network]</p>	<p>[Yes][No] [Not Applicable]</p> <p>[Same as Network]</p>

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Description of Covered Health Service	Must You Notify Us?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
Hospital as a result of an Emergency, you must notify us within one business day or the same day of admission, or as soon as reasonably possible.				
Group [text]				
<i>2-3</i> When the benefit plan design is to reduce benefits by one-half, insert a number that is one-half of the non-network benefit level (i.e. if the out of network Copayment is 20%, the benefit level is 80% and the number to insert here is 40.)				
Group [text]				
<i>2-3</i> When the benefit plan design is to reduce benefit to 50%, insert 50%.				
If you don't notify us, Benefits for the non-Network Hospital Inpatient Stay will be reduced to [ <i>2-3</i> 25-50%] of Eligible Expenses. Benefits will not be reduced for the outpatient Emergency Health Services.				

***[Outpatient Surgery, Diagnostic and Therapeutic Services described in (Section 1: What's Covered--Benefits) is replaced with the following:***

**Benefit Information**

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

**Outpatient Surgery, Diagnostic and Therapeutic Services**

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Description of Covered Health Service	Must You Notify Us?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<hr/>				
<p><b><i>Outpatient Surgery</i></b> Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>Administrative [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.</p> <p>Administrative [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.</p> <p>Benefits under this section include only the facility charge and the charge for <sup>1</sup>required Hospital-based professional services,] supplies and equipment. Benefits for the surgeons fees <sup>2</sup>and facility-based Physician's fees] related to outpatient surgery are described under <i>Professional Fees for Surgical and Medical Services</i>.</p>	<u><b>Network</b></u> No	[ \$[0 - 1,000] per surgical procedure ] [ [0 - 50]% ] [ No Copayment ] [ <sup>1</sup> Your Copayment will range between \$[0 - 3,000] per surgical procedure ]	[Yes][No]	[Yes][No] [Not Applicable]
<p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.</p> <p>Group [text] <sup>1</sup>Include if Benefit design includes a variable Copayment depending upon the Network provider selected.</p> <p><b>[<sup>1</sup> For Network Benefits, the Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]</b></p>	<u><b>Non-Network</b></u> No	[0 - 50]%	[Yes][No]	[Yes][No]

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Description of  
Covered Health Service

Must  
You  
Notify Us?

Your Copayment  
Amount  
% Copayments are  
based on a percent of  
Eligible Expenses

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

[Do You Need  
to Meet Annual  
Deductible?]

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[United HealthCare Insurance Company]

Description of Covered Health Service	Must You Notify Us?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<b><i>Outpatient Diagnostic Services</i></b>				
Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:				
<ul style="list-style-type: none"> <li>• Lab and radiology/X-ray.</li> <li>• Mammography testing.</li> </ul>	<b><u>Network</u></b>	<b><i>For preventive diagnostic services:</i></b>		
<small>Administrative [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.</small> <small>Administrative [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.</small>	No	\$[0 - 1,000] per test [[0 - 50]%] [No Copayment]	[Yes][No]	[Yes][No] [Not Applicable]
Benefits under this section include the facility charge, <sup>2</sup> and the charge for required services, supplies and equipment <sup>1</sup> , and all related professional fees]. <sup>2</sup> Benefits for facility-based Physician's fees related to these services are described under <i>Professional Fees for Surgical and Medical Services.</i>	No	<b><i>For preventive mammography testing:</i></b>		
<small>Prdct. Design[text] <sup>1</sup>Include if Non-Network Benefits are provided for preventive care.</small> <small>Prdct. Design[text] <sup>2</sup>Include if Non-Network Benefits are not provided for preventive care.</small>	No	\$[0 - 1,000] per test [[0 - 50]%] [No Copayment]	[Yes][No]	[Yes][No] [Not Applicable]
When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.  This section does not include Benefits for CT scans, PET scans, MRIs, or nuclear medicine, which are described immediately below.	<b><u>Non-Network</u></b>	[[ <sup>1</sup> 0 - 50]%] [ <sup>2</sup> No Benefits for preventive care except for children under the age of 19.]	[ <sup>1</sup> Yes][ <sup>1</sup> No] [ <sup>2</sup> No Benefits for preventive care except for children under the age of 19.]	[ <sup>1</sup> Yes][ <sup>1</sup> No] [ <sup>2</sup> No Benefits for preventive care except for children under the age of 19.]

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Description of Covered Health Service	Must You Notify Us?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
		<i>For Sickness and Injury-related diagnostic services:</i>		
	<u>Network</u> No	[\$[0 - 1,000] per test [[0 - 50] %] [No Copayment]	[Yes][No]	[Yes][No] [Not Applicable]
	<u>Non-Network</u> No	[0 - 50] %	[Yes][No]	[Yes][No]

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[United HealthCare Insurance Company]

Description of Covered Health Service	Must You Notify Us?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<b><i>Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine</i></b>				
<p>Covered Health Services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>Administrative [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.</p> <p>Administrative [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.</p> <p>Benefits under this section include the facility charge, <sup>2</sup>and] the charge for required services, supplies and equipment<sup>1</sup>, and all related professional fees]. <sup>2</sup>Benefits for facility-based Physician's fees related to these services are described under <i>Professional Fees for Surgical and Medical Services.</i></p> <p>Group [text] <sup>1</sup>Include if Benefit design includes a variable Copayment depending upon the Network provider selected.</p> <p><b><i>[For Network benefits, the Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]</i></b></p>	<u><b>Network</b></u> No	[ \$[0 - 1,000] per test [[0 - 50]%] [No Copayment] [ <sup>1</sup> Your Copayment will range between \$[0 - 3,000] per test]	[Yes][No]	[Yes][No] [Not Applicable]
	<u><b>Non-Network</b></u> No	[0 - 50]%	[Yes][No]	[Yes][No]

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Description of Covered Health Service	Must You Notify Us?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<b><i>Outpatient Therapeutic Treatments</i></b>				
<p>Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.</p> <p>Administrative [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.</p> <p>Administrative [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.</p>	<b><u>Network</u></b> No	<p>[\$[0 - 1,000] per treatment] [[0 - 50] %] [No Copayment]</p>	[Yes][No]	[Yes][No] [Not Applicable]
<p>Benefits under this section include the facility charge, <sup>2</sup>and] the charge for required services, supplies and equipment<sup>1</sup>, and all related professional fees]. <sup>2</sup>Benefits for facility-based Physician's fees related to these services are described under <i>Professional Fees for Surgical and Medical Services</i>.]</p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.</p>	<b><u>Non-Network</u></b> No	[0 - 50] %	[Yes][No]	[Yes][No]

***[Physician's Office Services described in (Section 1: What's Covered--Benefits) is replaced with the following:***

## Benefit Information

Description of Covered Health Service	Must You Notify Us?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
Group [text] <sup>3</sup> Include when a separate Network Copayment for a Specialist Physician office visit applies.	<u><b>Network</b></u> No	[\$[0 - 75] per visit] [[0 - 50]%] <sup>3</sup> , except that the Copayment for a Network Specialist Physician office visit is[\$[0 - 100]] [[0 - 50]%] [No Copayment applies when no Physician charge is assessed.] [No Copayment] <sup>5</sup> Your Copayment will range between \$[0 - 75] per visit]	[Yes][No]	[Yes. Prostate Cancer Screenings not subject to Annual Deductible.] [No] [Not Applicable]
Group [text] <sup>4</sup> Include when a separate non-Network Copayment for a Specialist Physician office visit applies.				
<h2 style="margin: 0;">Physician's Office Services</h2> <p style="margin: 0;"><b>Covered Health Services for preventive medical care.</b></p> <p style="margin: 0;">Preventive medical care includes:</p> <ul style="list-style-type: none"> <li>• Voluntary family planning.</li> </ul>				
<p style="margin: 0;"><b>State Mandate</b></p> <ul style="list-style-type: none"> <li>• Well-baby and well-child care. Care shall include 20 visits at approximately the following age intervals: Birth, 2 Weeks, 2 Months, 4 Months, 6 Months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years and 18 years.</li> <li>• Routine physical examinations.</li> <li>• Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See <i>Eye Examinations</i> earlier in this section.)</li> <li>• Immunizations. Please Note: No Copayment, Coinsurance or Deductible will be applicable to children's immunization services.</li> </ul>				

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Description of Covered Health Service	Must You Notify Us?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<ul style="list-style-type: none"> <li>Prostate Cancer Screenings provided at minimum one (1) screening per [calendar][Policy] year for any male Covered Person forty (40) years of age or older.</li> </ul> <p>Prdct. Design[text] <sup>1</sup>Include if Non-Network Benefits are provided for preventive care. Prdct. Design[text] <sup>2</sup>Include if Non-Network Benefits are not provided for preventive care.</p> <p><u>Product Design [Para]</u> Include if Benefits for preventive care are limited.</p> <p>[Benefits for preventive medical care are limited to [1 - 5] visit[s] per Covered Person per [calendar] [Policy] year. [This limit does not apply to Enrolled Dependent children under the age of 19.]]</p>	<p><b><u>Non-Network</u></b> [<sup>1</sup>No] [<sup>2</sup>Non-Network Benefits are not available except for preventive care for children under the age of 19.]</p>	<p>[<sup>1</sup>[0 - 50]%] [<sup>4</sup>, except that the Copayment for a Specialist Physician office visit is [0-50]%)] [<sup>2</sup>Non-Network Benefits are not available except for preventive care for children under the age of 19.]</p>	<p>[<sup>1</sup>[Yes][No]] [<sup>2</sup>Non-Network Benefits are not available except for preventive care for children under the age of 19.]</p>	<p>[<sup>1</sup>[Yes. Prostate Cancer Screenings not subject to Annual Deductible.] [No]] [<sup>2</sup>Non-Network Benefits are not available except for preventive care for children under the age of 19.]</p>

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Description of Covered Health Service	Must You Notify Us?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>Covered Health Services for the diagnosis and treatment of a Sickness or Injury.</b></p> <p>Group [text] <sup>5</sup>Include if Benefit design includes a variable Copayment for Network Benefits depending upon the Network provider selected.</p> <p><sup>5</sup><i>For Network Benefits, the Copayments that apply to Physician's Office Services are based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.</i></p>	<u>Network</u>	<p>[No Copayment applies when no Physician charge is assessed.]</p> <p>[No Copayment]</p> <p>[<sup>5</sup>Your Copayment will range between \$[0 - 75] per visit]</p>	<p>[Yes][No]</p>	<p>[Yes][No]</p> <p>[Not Applicable]</p>
	No			
	<u>Non-Network</u>	<p>[No Copayment]</p> <p>[<sup>5</sup>Your Copayment will range between \$[0 - 75] per visit]</p>	<p>[Yes][No]</p>	<p>[Yes][No]</p>
	No			

*[Professional Fees for Surgical and Medical Services described in (Section 1: What's Covered--Benefits) is replaced with the following:*

## Benefit Information

Description of Covered Health Service	Must You Notify Us?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>Professional Fees for Surgical and Medical Services</b></p> <p>Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.</p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> above.</p>	<u>Network</u>	[[0 – 50]%] [No Copayment] [ <sup>1</sup> Your Copayment will range between [0 - 50]%]	[Yes][No]	[Yes][No] [Not Applicable]
	<u>Non-Network</u>	No	[0 - 50]%	[Yes][No]
<p>Group [text] <sup>1</sup>Include if Benefit design includes a variable Copayment for Network Benefits depending upon the Network provider selected.</p> <p>[<sup>1</sup> For Network Benefits, the Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]</p>				[Yes][No]

## [Section 10: Glossary of Defined Terms]

**[The definition of Annual Deductible is replaced with the following:**

Group [Para]	Include if group chooses a plan design with an Annual Deductible provision.
Group [text]	<sup>1</sup> Include text if the Annual Deductible applies only to Non-Network Benefits. Delete text if both Network and Non-Network Benefits are subject to payment of an Annual Deductible. Match with information in Table in Section 1.
Group [text]	<sup>2</sup> Include when an Outpatient Prescription Drug Rider is sold and the Annual Deductible applies to any combination of medical and RX benefits.

**[Annual Deductible** - the amount you must pay for Covered Health Services in a [calendar] [Policy] year before we will begin paying for [<sup>1</sup>Non-Network] Benefits in that [calendar] [Policy] year. [<sup>2</sup>The Annual Deductible applies to all Covered Health Services under the Policy, including Covered Health Services provided under the Outpatient Prescription Drug Rider.]

Group [Para] Include paragraph only if the carry-over provision applies.  
[Any amount you pay for medical expenses in the last three months of the previous [calendar] [Policy] 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.]]

**[The definition of Out-of-Pocket Maximum is replaced with the following:**

Group [Para] Include if group chooses a plan design that includes an Out-of-Pocket-Maximum provision.

Group [text]	<sup>1</sup> Include if Annual Deductible provision applies and if the OOPM includes the Annual Deductible.
Group [text]	<sup>2</sup> Delete if combined Network/Non-Network Out-of-Pocket Maximum applies.
Group [text]	<sup>3</sup> Include if combined Network/Non-Network Out-of-Pocket Maximum applies.
Group [text]	<sup>4</sup> Include when an Outpatient Prescription Drug Rider is sold and the Out-of-Pocket Maximum applies to any combination of medical and RX benefits.
Group [text]	<sup>5</sup> Delete if benefit plan design applies all Copayments in Section 1 to the OOPM.

**[Out-of-Pocket Maximum** - the maximum amount of [<sup>1</sup>Annual Deductible and] Copayments you pay every [calendar] [Policy] year. [<sup>2</sup>If you use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once you reach the Out-of-Pocket Maximum for Network Benefits, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that [calendar] [Policy] year. Once you reach the Out-of-Pocket Maximum for Non-Network Benefits, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that [calendar] [Policy] year.] [<sup>3</sup>Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that [calendar] [Policy] year.] [<sup>4</sup>The Out-of-Pocket Maximum applies to all Covered Health Services under the Policy, including Covered Health Services provided under the Outpatient Prescription Drug Rider.] [<sup>5</sup>Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in (Section

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1: What's Covered--Benefits) and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.]

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services.

**Group [Para]** Exclude when an Outpatient Prescription drug Rider is sold and the Out-of-Pocket Maximum applies to any combination of medical and Rx benefits.

- [Copayments for Covered Health Services available through any Outpatient Prescription Drug Rider.]
- The amount of any reduced Benefits if you don't notify us as described in (Section 1: What's Covered--Benefits) under the *Must You Notify Us?* column.
- Charges that exceed Eligible Expenses.
- Any Copayments for Covered Health Services in (Section 1: What's Covered--Benefits) that do not apply to the Out-of-Pocket Maximum.

**Group [text]** <sup>2</sup>Include if an Annual Deductible provision applies, but is not included in the OOPM.

- [<sup>2</sup>The Annual Deductible.]

Even when the Out-of-Pocket Maximum has been reached, you will still be required to pay:

- Any charges for non-Covered Health Services.
- Charges that exceed Eligible Expenses.
- The amount of any reduced Benefits if you don't notify us as described in (Section 1: What's Covered--Benefits) under the *Must You Notify Us?* column.

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

**Group [Para]** Exclude when an Outpatient Prescription drug Rider is sold and the Out-of-Pocket Maximum applies to any combination of medical and Rx benefits.

- [Copayments for Covered Health Services available through any Outpatient Prescription Drug Rider.]
- Copayments for Covered Health Services in (Section 1: What's Covered--Benefits) that are subject to Copayments that do not apply to the Out-of-Pocket Maximum.]]

**[The definition of Specialist Physician is added:**

**Group [Para]** Include when a separate Copayment for a Specialist Physician office visit applies.

**[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.]]

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(Name and Title)

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# 2002 Amendment to the Certificate of Coverage

*The Certificate of Coverage is modified as described in this Amendment.*

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## [Section 1: What's Covered - Benefits]

***["Accessing Benefits" in (Section 1: What's Covered - Benefits) is replaced with the following:]***

### **[Accessing Benefits]**

Admin. [text] <sup>1</sup>Include text if the plan design supports denying benefits for any service provided by a non-network facility-based Physician.

[To obtain Benefits, Covered Health Services must be provided by a Network Physician or other Network provider in the Physician's office or at a Network facility.

[<sup>1</sup>There are no Benefits for Covered Health Services provided in a Network facility by a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist).]

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

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

you are enrolled under a [UnitedHealthcare] Policy. As a result, they may bill you for the entire cost of the services you receive.

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

- Covered Health Services are received while the group Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in (Section 8: When Coverage Ends) occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.]

*[To continue reading, go to left column on next page.]*

**[The following information is added to the Payment Information table in (Section 1: What's Covered - Benefits):]**

**[Payment Information]**

**Plan [Para]** Include if a separate deductible applies to Mental Health Services, Substance Abuse Services, or a combination of both.  
**Plan [text]** <sup>1</sup>Include references to describe if this deductible applies only to Mental Health Services, only to Substance Abuse Services, or to a combination of both.

**[The following payment information applies to Benefits for [<sup>1</sup>Mental Health Services] [<sup>1</sup>and] [<sup>1</sup>Substance Abuse Services].]**

Payment Term	Description	Amounts
<p><b>[<sup>1</sup>Mental Health Services] [<sup>1</sup>and] [<sup>1</sup>Substance Abuse Services] Deductible]</b></p>	<p>Plan [text] <sup>1</sup>Include references to describe if this deductible applies only to Mental Health Services, only to Substance Abuse Services, or to a combination of both.</p> <p>[The amount you must pay for Covered [<sup>1</sup>Mental Health Services] [<sup>1</sup>and] [<sup>1</sup>Substance Abuse Services] before you are eligible to receive Benefits.]</p>	<p>Group [text] <sup>1</sup>Insert appropriate amount for deductible.                  [\$<sup>1</sup>0 - 25,000] per Covered Person per [calendar] [Policy] year.]</p>

**[The following information is added to the Payment Information table in (Section 1: What's Covered - Benefits):]**

**[Payment Information]**

**Plan [Para]** Include if a separate OOPM applies to Mental Health Services, Substance Abuse Services, or a combination of both.  
**Plan [text]** <sup>1</sup>Include references to describe if this OOPM applies only to Mental Health Services, only to Substance Abuse Services, or to a combination of both.

**[The following payment information applies to Benefits for <sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services].]**

Payment Term	Description	Amounts
<b>[<sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services] Out-of-Pocket Maximum ]</b>	<b>Plan [text]</b> <sup>1</sup> Include references to describe if this OOPM feature applies only to Mental Health Services, only to Substance Abuse Services, or to a combination of both.	<b>Group [text]</b> <sup>1</sup> Insert appropriate amount of OOPM. <b>[\$<sup>1</sup>0 - 25,000] per Covered Person per [calendar][Policy] year.]</b>
	<b>Group [text]</b> <sup>2</sup> include when overall OOPM provision applies. <b>[The maximum you pay, out of your pocket, in a [calendar][Policy] year for Copayments for <sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services]. <sup>2</sup>This amount is not included in the overall Out-of-Pocket Maximum stated in your Certificate.]]</b>	<b>Plan [Para]</b> Include when this OOPM provision and either the Annual Deductible provision or the MH/SA deductible provisions apply. <b>Plan [text]</b> <sup>1</sup> Include references to describe if this OOPM feature applies only to Mental Health Services, only to Substance Abuse Services, or to a combination of both. <b>Group [text]</b> <sup>2</sup> include if an Annual Deductible provision applies. <b>[This <sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services] Out-of-Pocket Maximum does not include <sup>2</sup>the Annual Deductible or] the <sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services] Deductible.]</b>

**[Durable Medical Equipment described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Durable Medical Equipment]</b> Durable Medical Equipment that meets each of the following criteria:</p> <ul style="list-style-type: none"> <li>• Ordered or provided by a Physician for outpatient use.</li> <li>• Used for medical purposes.</li> <li>• Not consumable or disposable.</li> <li>• Not of use to a person in the absence of a disease or disability.</li> </ul> <p>If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment.</p> <p>Examples of Durable Medical Equipment include:</p> <ul style="list-style-type: none"> <li>• Equipment to assist mobility, such as a standard wheelchair.</li> <li>• A standard Hospital-type bed.</li> <li>• Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).</li> <li>• Delivery pumps for tube feedings (including tubing and connectors).</li> <li>• Braces, including necessary adjustments to shoes to</li> </ul>	<p>[[0 - 50]%] [No Copayment]</p>	<p>[Yes] [No]</p>	<p>[Yes][No]</p>

**[Description of Covered Health Service]**

**[Your Copayment Amount]**

% Copayments are based on a percent of Eligible Expenses]

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

**[Do You Need to Meet Annual Deductible?]**

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. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also 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).

Group [text] <sup>1</sup>Include when group chooses a plan with DME purchase of every two-five years. The standard is once every three years.

Group [text] <sup>2</sup>Include when group chooses a plan with DME purchase of once every year.

We provide Benefits only for a single purchase (including repair/ replacement) of a type of Durable Medical Equipment once every <sup>1</sup>two-five [calendar] [Policy] <sup>1</sup>years][<sup>2</sup>year].

We will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor we identify.

Group [Para] Include when a group chooses to limit benefit.

Group [text] <sup>1</sup>Insert benefit limit selected by group. Standard options are \$750, \$1,000, \$1,500, \$2,000 or \$2,500.

Group [text] <sup>2</sup>Include if Annual Deductible provision applies.

[Benefits for Durable Medical Equipment are limited to <sup>1</sup>\$750 - \$100,000] per [calendar] [Policy] year. This limit applies to the total amount that we will pay for the Durable Medical Equipment, and

**[Description of Covered Health Service]**

**[Your Copayment Amount]**

% Copayments are based on a percent of Eligible Expenses]

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

**[Do You Need to Meet Annual Deductible?]**

does not include any Copayment <sup>2</sup>or Annual Deductible] responsibility you may have.]]

**[Home Health Care described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

**[Description of Covered Health Service]**

**[Your Copayment Amount]**

% Copayments are based on a percent of Eligible Expenses]

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

**[Do You Need to Meet Annual Deductible?]**

**[Home Health Care]**

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

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home.

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent 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

[\$[0 - 50] per visit]

[[0 - 50]%]

[No Copayment]

<sup>2</sup>Your

Copayment will range between \$[0 - 50] per visit]

[Yes][No]

[Yes][No]

**[Description of Covered Health Service]**

**[Your Copayment Amount**

% Copayments are based on a percent of Eligible Expenses]

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

**[Do You Need to Meet Annual Deductible?]**

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 decide if skilled care is required 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.

Group [Para] Include when group chooses to limit benefit.

Group [text] <sup>1</sup>Insert benefit limit selected by group. Standard is 60 visits.

[Benefits are limited to [<sup>1</sup>40 - 200] visits per [calendar][Policy] year. One visit equals four hours of skilled care services.]

Group [text] <sup>2</sup>Include if Benefit design includes a variable Copayment depending upon the Network provider selected.

**[<sup>2</sup>The Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]]**

*[Hospital - Inpatient Stay described in Section 1: (What's Covered - Benefits) is replaced with the following:]*

**[Benefit Information]**

[Description of Covered Health Service]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Hospital - Inpatient Stay]</b>                      Inpatient Stay in a Hospital. Benefits are available for:</p> <ul style="list-style-type: none"> <li>Supplies and non-Physician services received during the Inpatient Stay.</li> <li>Room and board in a Semi-private Room (a room with two or more beds).</li> </ul> <p>Admin. [text] <sup>1</sup>Include when facility-based Physicians are paid depending upon Network status and not as part of the facility charge.</p> <p>Benefits for Physician services <sup>1</sup>(including facility-based Physician services) are described under <i>Professional Fees for Surgical and Medical Services</i>.</p> <p>Group [text] <sup>3</sup>Include if Benefit design includes a variable Copayment depending upon the Network provider selected.</p> <p><sup>2</sup><i>The Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]]</i></p>	<p>[[0 - 50]%]                      [0 - 25,000] per Inpatient Stay]                      [0 - 1,000] per day]                      [0 - 1,000] per day to a maximum of \$[0 - 5,000] per Inpatient Stay]                      [No Copayment]                      [2]\$Your Copayment will range between \$[0 - 1,200] per day[, to a maximum of 4 days].]</p>	<p>[Yes] [No]</p>	<p>[Yes][No]</p>

**[Outpatient Surgery, Diagnostic and Therapeutic Services described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Outpatient Surgery, Diagnostic and Therapeutic Services</b></p> <p><i>Outpatient Surgery</i></p> <p>Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>Admin. [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.</p> <p>Admin. [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.</p> <p>Benefits under this section include only the facility charge and the charge for <sup>1</sup>required Hospital-based professional services, supplies and equipment. Benefits for the surgeon's fees <sup>2</sup>and facility-based Physician's fees related to outpatient surgery are described under <i>Professional Fees for Surgical and Medical Services</i>.</p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.</p> <p>Group [text] <sup>1</sup>Include if Benefit design includes a variable Copayment depending upon the Network provider selected.</p> <p><sup>1</sup> <b>The Copayment that applies to this Benefit is based on</b></p>	<p>[ \$[0 - 1,000] per surgical procedure ] [ [0 - 50]% ]</p> <p>[No Copayment]</p> <p>[<sup>1</sup>Your Copayment will range between \$[0 - 3,000] per surgical procedure]</p>	<p>[Yes] [No]</p>	<p>[Yes][No]</p>

[Description of Covered Health Service]

[Your Copayment Amount

% Copayments are based on a percent of Eligible Expenses]

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

[Do You Need to Meet Annual Deductible?]

*which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]*

**Outpatient Diagnostic Services**

Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:

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

Admin. [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.  
 Admin. [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.

Benefits under this section include the facility charge, <sup>1</sup>and the charge for required services, supplies and equipment<sup>1</sup>, and all related professional fees]. <sup>2</sup>Benefits for facility-based Physician's fees related to these services are described under *Professional Fees for Surgical and Medical Services.*

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

This section does not include Benefits for CT scans, Pet scans, MRIs, or nuclear medicine, which are described immediately below.

*For lab and radiology/Xray:*

[\$[0 - 1,000] per test]  
 [[0 - 50]% ]  
 [No Copayment]

[Yes][No]

[Yes][No]

*For mammography testing:*

[\$[0 - 1,000] per test]  
 [[0 - 50]% ]  
 [No Copayment]

[Yes][No]

[Yes][No]

[Description of Covered Health Service]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b><i>Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine</i></b></p> <p>Covered Health Services for CT scans, Pet scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>Admin. [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.</p> <p>Admin. [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.</p> <p>Benefits under this section include the facility charge, <sup>1</sup>and the charge for required services, supplies and equipment<sup>1</sup>, and all related professional fees]. <sup>2</sup>Benefits for facility-based Physician's fees related to these services are described under <i>Professional Fees for Surgical and Medical Services.</i></p> <p>Group [text] <sup>1</sup>Include if Benefit design includes a variable Copayment depending upon the Network provider selected.</p> <p><sup>1</sup><b><i>The Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.</i></b></p> <p><b><i>Outpatient Therapeutic Treatments</i></b></p> <p>Covered Health Services for therapeutic treatments received on an</p>	<p>[\$0 - 1,000] per test [[0 - 50]%] [No Copayment] <sup>1</sup>Your Copayment will range between \$[0 - 3,000] per test]</p>	<p>[Yes][No]</p>	<p>[Yes][No]</p>
<p><b><i>Outpatient Therapeutic Treatments</i></b></p> <p>Covered Health Services for therapeutic treatments received on an</p>	<p>[\$0 - 1,000] per</p>	<p>[Yes][No]</p>	<p>[Yes][No]</p>

[Description of Covered Health Service]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.</p>	<p>treatment [[0 - 50]% ] [No Copayment]</p>		
<p>Admin. [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge. Admin. [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.</p>			
<p>Benefits under this section include the facility charge, <sup>1</sup>and the charge for required services, supplies and equipment<sup>1</sup>, and all related professional fees]. <sup>2</sup>Benefits for facility-based Physician's fees related to these services are described under <i>Professional Fees for Surgical and Medical Services</i>.</p>			
<p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.]</p>			

**[Physicians Office Services described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Physician's Office Services]</b> Covered Health Services received in a Physician's office including:</p> <ul style="list-style-type: none"> <li>• Diagnosis and treatment of a Sickness or Injury.</li> <li>• Preventive medical care.</li> <li>• Voluntary family planning.</li> <li>• Routine physical examinations.</li> <li>• Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See <i>Eye Examinations</i> earlier in this section.)</li> <li>• Well-baby and well-child care. Care shall include 20 visits at approximately the following age intervals: Birth, 2 Weeks, 2 Months, 4 Months, 6 Months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years and 18 years.</li> <li>• Immunizations. Please Note: No Copayment, Coinsurance or Deductible will be applicable to Children's Immunization Services.</li> </ul>	<p>[[ \$5 - 75 ] per visit] [No Copayment applies when no Physician charge is assessed.]] [0 - 50%] [No Copayment] [<sup>1</sup>Your Copayment will range between \$[0 - 75] per visit] [[ \$5 - 75 ] per visit], except that the Copayment for a Specialist Physician is \$[5 - 75] per visit [No Copayment applies when no Physician charge is assessed.]]</p>	<p>[Yes][No]</p>	<p>[Yes. Prostate Cancer Screenings not subject to Annual Deductible.] [No]</p>
<p><b>State Mandate</b></p> <ul style="list-style-type: none"> <li>• Prostate Cancer Screenings provided at minimum one (1) screening per [calendar][Policy] year for any male Covered</li> </ul>			

**[Description of Covered Health Service]**

**[Your Copayment Amount]**

% Copayments are based on a percent of Eligible Expenses]

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

**[Do You Need to Meet Annual Deductible?]**

Person forty (40) years of age or older.

Group [text]

<sup>1</sup>Include if Benefit design includes a variable Copayment depending upon the Network provider selected.

**[<sup>1</sup>The Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]]**

**[Professional Fees for Surgical and Medical Services described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Professional Fees for Surgical and Medical Services]</b> Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.</p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> above.</p>	<p>[[0 - 50] %] [No Copayment]</p>	<p>[Yes] [No]</p>	<p>[Yes][No]</p>

**[Prosthetic Devices described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Prosthetic Devices]</b> External prosthetic devices that replace a limb or an external body</p>	<p>[[0 - 50] %] [No Copayment]</p>	<p>[Yes] [No]</p>	<p>[Yes][No]</p>

**[Description of Covered Health Service]**

**[Your Copayment Amount]**

% Copayments are based on a percent of Eligible Expenses]

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

**[Do You Need to Meet Annual Deductible?]**

part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial eyes, ears and noses.
- 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.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.

Group [text] <sup>1</sup>Include when group chooses a plan with a Prosthetic purchase every two or more years. The standard is once every three years.

Group [text] <sup>2</sup>Include when group chooses a plan with a Prosthetic purchase of once every year.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every [<sup>1</sup>two-five] [calendar] [Policy] [<sup>1</sup>years][<sup>2</sup>year].

Group [Para] Include when group chooses to limit benefit.

Group [text] <sup>1</sup>Insert benefit limit selected by group. Standard options are \$2,500 and \$5,000.

Group [text] <sup>2</sup>Include if Annual Deductible provision applies.

[Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to [<sup>1</sup>\$2,500-\$100,000] per [calendar] [Policy] year. This limit applies to

**[Description of Covered Health Service]**

**[Your Copayment Amount]**

% Copayments are based on a percent of Eligible Expenses]

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

**[Do You Need to Meet Annual Deductible?]**

the total amount that we will pay for the prosthetics, and does not include any Copayment [<sup>2</sup>or Annual Deductible] responsibility you may have.

Once this Benefit limit is reached, no additional Benefits are available except for items required by the Women's Health and Cancer Rights Act of 1998.]]

**[Rehabilitation Services - Outpatient Therapy described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

**[Description of Covered Health Service]**

**[Your Copayment Amount]**

% Copayments are based on a percent of Eligible Expenses]

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

**[Do You Need to Meet Annual Deductible?]**

**[Rehabilitation Services - Outpatient Therapy**

Short-term outpatient rehabilitation services for:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

[\$[5 - 75] per visit] [[0 - 50]%]  
[No Copayment]  
[<sup>2</sup>Your Copayment will range between \$[0 - 75] per visit]

[Yes] [No]

[Yes][No]

**[Description of Covered Health Service]**

**[Your Copayment Amount]**

% Copayments are based on a percent of Eligible Expenses]

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

**[Do You Need to Meet Annual Deductible?]**

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.

Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment.

Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.

Group [Para] Include when group chooses to limit benefit.  
 Group [text] <sup>1</sup>Insert benefit limit selected by group. Standard is 20 visits for each, except that standard for cardiac therapy is 36 visits.

[Benefits are limited as follows:

- [<sup>1</sup>10-100] visits of physical therapy per [calendar][Policy] year.
- [<sup>1</sup>10-100] visits of occupational therapy per [calendar][Policy] year.
- [<sup>1</sup>10-100] visits of speech therapy per [calendar][Policy] year.
- [<sup>1</sup>10-100] visits of pulmonary rehabilitation therapy per [calendar][Policy] year.
- [<sup>1</sup>10-100] visits of cardiac rehabilitation therapy per [calendar][Policy] year.]

Group [text] <sup>2</sup>Include if Benefit design includes a variable Copayment depending upon the Network provider selected.

**[<sup>2</sup>The Copayment that applies to this Benefit is based on**

[Description of Covered Health Service]

[Your Copayment Amount  
% Copayments are based on a percent of Eligible Expenses]

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

[Do You Need to Meet Annual Deductible?]

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*which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]]*

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## [Section 2: What's Not Covered - Exclusions]

*[Section 2 is modified by replacing exclusion #3 under Medical Supplies and Appliances with the following exclusion:]*

### [Medical Supplies and Appliances]

- [3. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces).]

*[Section 2 is modified by replacing exclusion #3 under Mental Health/Substance Abuse with the following exclusion:]*

### [Mental Health/Substance Abuse]

- [3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.]

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

*[To continue reading, go to left column on next page.]*

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## [Section 3: Obtaining Benefits]

*[The introductory portion of the Benefits section in (Section 3: Obtaining Benefits) is replaced with the following:]*

### [Benefits]

[Benefits are payable for Covered Health Services which are any of the following:

Admin. [text] <sup>1</sup>Include text if the plan design supports denying benefits for any service provided by a non-network facility-based Physician.

- Provided by a Network Physician or other Network provider in the Physician's office or at a Network facility.
- Emergency Health Services.
- Urgent Care Center services received outside the Service Area.

Benefits are not payable for Covered Health Services that are provided by non-Network providers.

<sup>1</sup>Benefits are not available for Covered Health Services provided in a Network facility by a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist).]

*[Designated Facilities and Other Providers in (Section 3: Obtaining Benefits) is replaced with the following:]*

### [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 other provider chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a non-Network facility or provider.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility or other provider chosen by us.

You or your Network Physician must notify us of special service needs (including, but not limited to, transplants or cancer treatment) that might warrant referral to a Designated Facility or non-Network facility or provider. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.]

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

[To continue reading, go to left column on next page.]

***[Emergency Health Services in (Section 3: Obtaining Benefits) is replaced with the following:]***

## **[Emergency Health Services]**

[We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network provider.

If you are confined in a non-Network Hospital after you receive Emergency Health Services, we must be notified within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be available.]

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

*[To continue reading, go to left column on next page.]*

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## Section 9: General Legal Provisions

**[Subrogation and Reimbursement is replaced with the following:]**

### **[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 of Coverage, 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.

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

- 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 sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

*[To continue reading, go to left column on next page.]*

UnitedHealthcare of Arkansas, Inc.

- In the event that you recover from a Third Party, we agree to pay our share of the reasonable costs of collection and attorney fees in the proportion we benefit from the recovery.
- 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.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors for 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.]

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## [Section 10: Glossary of Defined Terms]

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

[To continue reading, go to left column on next page.]

**[The definition of Alternate Facility is replaced with the following:]**

**[Alternate Facility]** - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.]

Group [text] <sup>1</sup>Include text as standard for groups that purchase MH/SA coverage. Delete text if group has not purchased MH/SA benefits

<sup>1</sup>An Alternate Facility may also provide Mental Health Services or Substance Abuse Services on an outpatient or inpatient basis.]

**[The definition of Designated Facility is replaced with the following:]**

**[Designated Facility]** - a facility that has entered into an agreement on behalf of the facility and its affiliated staff 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.]

**[The definition of Eligible Expenses is replaced with the following:]**

**[Eligible Expenses]** - the amount we will pay for Covered Health Services, incurred while the Policy is in effect, are determined as stated below:

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

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated.

**[The definition of Network is replaced with the following:]**

**[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. 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.]

**[The definition of Out-of-Pocket Maximum is replaced with the following:]**

Group [Para] Include if group chooses a plan design that includes an Out-of-Pocket-Maximum provision.  
Group [text] <sup>1</sup>Include if Annual Deductible provision applies and if the OOPM includes the Annual Deductible.

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**[Out-of-Pocket Maximum** - the maximum amount of [<sup>1</sup>Annual Deductible and] Copayments you pay every [calendar] [Policy] year. Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that [calendar] [Policy] year. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in (Section 1: What's Covered--Benefits) and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services.
- Copayments for Covered Health Services available by an optional Rider.
- Any Copayments for Covered Health Services in Section 1: What's Covered--Benefits) that do not apply to the Out-of-Pocket Maximum.

Group [text] <sup>2</sup>include if an Annual Deductible provision applies, but is not included in the OOPM.

- [<sup>2</sup>The Annual Deductible.]

Even when the Out-of-Pocket Maximum has been reached, you will still be required to pay:

- Any charges for non-Covered Health Services.
- Copayments for Covered Health Services available by an optional Rider.

- Copayments for Covered Health Services in (Section 1: What's Covered - Benefits) that are subject to Copayments that do not apply to the Out-of-Pocket Maximum.]

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# 2002 Amendment to the Certificate of Coverage

*The Certificate of Coverage is modified as described in this Amendment.*

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## [Section 1: What's Covered - Benefits]

***["Accessing Benefits" in (Section 1: What's Covered - Benefits) is replaced with the following:]***

### **[Accessing Benefits]**

[You can choose to receive either Network Benefits or Non-Network Benefits. In most cases, you must see a Network Physician or other Network provider to obtain Network Benefits. For facility services, Network Benefits apply to Covered Health Services that are provided at a Network facility under the direction of either a Network or non-Network Physician or other provider.]

Admin. [text] <sup>1</sup>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).

[<sup>1</sup>Covered Health Services provided in a Network facility by a non-

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Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist) will be paid as Non-Network Benefits.]

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. For details about when Network Benefits apply, see (Section 3: Description of Network and Non-Network Benefits).

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

- Covered Health Services are received while the group Policy is in effect.

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- Covered Health Services are received prior to the date that any of the individual termination conditions listed in (Section 8: When Coverage Ends) occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

Admin. [text] <sup>1</sup>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 [<sup>1</sup>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, and if your Copayment is expressed as a percentage of Eligible Expenses for Non-Network Benefits, that percentage 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 when you receive Covered Health Services [<sup>1</sup>from [Shared Savings Program] providers than] from other non-Network providers, because the Eligible Expense may be a lesser amount.]

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**[The following information is added to the Payment Information table in (Section 1: What's Covered - Benefits):]**

**[Payment Information]**

**Plan [Para]** Include if a separate deductible applies to Mental Health Services, Substance Abuse Services, or a combination of both.  
**Plan [text]** <sup>1</sup>Include references to describe if this deductible applies only to Mental Health Services, only to Substance Abuse Services, or to a combination of both.

**[The following payment information applies to Benefits for [<sup>1</sup>Mental Health Services] [<sup>1</sup>and] [<sup>1</sup>Substance Abuse Services].]**

Payment Term	Description	Amounts	
<p><b>[<sup>1</sup>Mental Health Services] [<sup>1</sup>and] [<sup>1</sup>Substance Abuse Services] Deductible]</b></p>	Plan [text]	<b>[<u>Network</u>]</b>	
	Group [text]	<sup>1</sup> Include references to describe if this deductible applies only to Mental Health Services, only to Substance Abuse Services, or to a combination of both.	Group [Para] Include when deductible provision applies to Network Benefits
			Group [text] <sup>1</sup> Insert appropriate amount for deductible. <b>[\$<sup>1</sup>0 - 25,000] per Covered Person per [calendar] [Policy] year.]</b>
	Group [text]	<sup>2</sup> Include when deductible provision applies, but only to Non-Network Benefits.	Group [Para] Include when deductible provision does not apply to Network Benefits. <b>[This deductible provision does not apply]]</b>
			<b>[<u>Non-Network</u>]</b>
	[The amount you must pay for Covered [ <sup>1</sup> Mental Health Services] [ <sup>1</sup> and] [ <sup>1</sup> Substance Abuse Services] before you are eligible to receive [ <sup>2</sup> Non-Network] Benefits.]	Group [Para] Include when deductible applies to Non-Network Benefits	
	Group [text] <sup>1</sup> Insert appropriate amount for deductible <b>[\$<sup>1</sup>0 - 25,000] per Covered Person per [calendar] [Policy] year.]</b>		
	Group [Para] Include when deductible provision does not apply to Non-Network Benefits. <b>[This deductible provision does not apply.]]</b>		

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**[The following information is added to the Payment Information table in (Section 1: What's Covered - Benefits):]**

## **[Payment Information]**

**Plan [Para]** Include if a separate OOPM applies to Mental Health Services, Substance Abuse Services, or a combination of both.

**Plan [text]** <sup>1</sup>Include references to describe if this OOPM applies only to Mental Health Services, only to Substance Abuse Services, or to a combination of both.

**[The following payment information applies to Benefits for <sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services].]**

Payment Term	Description	Amounts
<p><b>[<sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services] Out-of-Pocket Maximum ]</b></p>	<p><b>Plan [text]</b> <sup>1</sup>Include references to describe if this OOPM feature applies only to Mental Health Services, only to Substance Abuse Services, or to a combination of both.</p> <p><b>Group [text]</b> <sup>2</sup>Include when overall OOPM provision applies.</p> <p><b>[The maximum you pay, out of your pocket, in a [calendar][Policy] year for Copayments for <sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services]. <sup>2</sup>This amount is not included in the overall Out-of-Pocket Maximum stated in your Certificate.]]</b></p>	<p><b>[<u>Network</u></b></p> <p><b>Group [Para]</b> Include when this OOPM provision applies to Network Benefits.</p> <p><b>Group [text]</b> <sup>1</sup>Insert appropriate amount of OOPM.  <b>[\$<sup>1</sup>0 - 25,000] per Covered Person per [calendar][Policy] year.]</b></p> <p><b>Plan [Para]</b> Include when this OOPM provision and either the Annual Deductible provision or the MH/SA deductible provisions apply for Network Benefits.</p> <p><b>Plan [text]</b> <sup>1</sup>Include references to describe if this OOPM feature applies only to Mental Health Services, only to Substance Abuse Services, or to a combination of both.</p> <p><b>Group [text]</b> <sup>2</sup>Include if an Annual Deductible provision applies to Network Benefits.  <b>[This <sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services] Out-of-Pocket Maximum does not include <sup>2</sup>the Annual Deductible or] the <sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services] Deductible.]</b></p> <p><b>Group [text]</b> Include if this OOPM provision does not apply to Network Benefits.  <b>[This out-of-pocket maximum provision does not apply.]]</b></p> <p style="text-align: center;"><b>[<u>Non-Network</u></b></p> <p><b>Group [Para]</b> Include when this OOPM provision applies to Non-Network Benefits.</p> <p><b>Group [text]</b> <sup>1</sup>Insert appropriate amount of OOPM.  <b>[\$<sup>1</sup>0 - 25,000] per Covered Person per [calendar][Policy] year.]</b></p> <p><b>Plan [Para]</b> Include when this OOPM provision and either the Annual Deductible provision or the MH/SA deductible provisions apply for Non-Network Benefits.</p> <p><b>Plan [text]</b> <sup>1</sup>Include references to describe if this OOPM feature applies only to Mental Health</p>

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Payment Term	Description	Amounts
	Services, only to Substance Abuse Services, or to a combination of both. Group [text] <sup>2</sup> Include if an Annual Deductible provision applies to Non-Network Benefits. [This [ <sup>1</sup> Mental Health Services] [and] [ <sup>1</sup> Substance Abuse Services] Out-of-Pocket Maximum does not include [ <sup>2</sup> the Annual Deductible or] the [ <sup>1</sup> Mental Health Services] [and] [ <sup>1</sup> Substance Abuse Services] Deductible.]	
	Group [text] Include if this OOPM provision does not apply to Non-Network Benefits. [This out-of-pocket maximum provision does not apply.]	

**[Durable Medical Equipment described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
Group [text] Must You Notify Us Column: <sup>1</sup> Include when group chooses a plan with an annual DME limit of more than \$1,000.	[ <u>Network</u> ] [No]	[[0 - 50]%] [No Copayment]	[Yes] [No]	[Not Applicable] [Yes][No]
Group [text] Must You Notify Us Column: <sup>2</sup> Include when group chooses a plan with an annual DME limit of \$1,000 or less per year.				

**[Durable Medical Equipment**

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a disease or disability.

[ <u>Non-Network</u> ] [ <sup>1</sup> Yes, for items more than \$1,000] [ <sup>2</sup> No]	[0 - 50]%	[Yes] [No]	[Yes][No]
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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
-----------------------------------------	-----------------------	-------------------------------------------------------------------------------------	---------------------------------------------------	------------------------------------------

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment.

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. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also 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).

Group [text] <sup>1</sup>Include when group chooses a plan with DME purchase of every two-five

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**[Description of Covered Health Service]**

**[Must You Notify Us?]**

**[Your Copayment Amount]**  
% Copayments are based on a percent of Eligible Expenses]

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

**[Do You Need to Meet Annual Deductible?]**

Group [text] years. The standard is once every three years.  
<sup>2</sup>Include when group chooses a plan with DME purchase of once every year.

We provide Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every [<sup>1</sup>two-five] [calendar] [Policy] [<sup>1</sup>years][<sup>2</sup>year].

We will decide if the equipment should be purchased or rented. To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify.

Group [Para] Include when a group chooses to limit benefit.  
Group [text] <sup>1</sup>Insert benefit limit selected by group. Standard options are \$750, \$1,000, \$1,500, \$2,000 or \$2,500.  
Group [text] <sup>2</sup>Include if Annual Deductible provision applies.

[Any combination of Network and Non-Network Benefits for Durable Medical Equipment is limited to [<sup>1</sup>\$750 - \$100,000] per [calendar] [Policy] year. This limit applies to the total amount that we will pay for the Durable Medical Equipment, and does not include any Copayment [<sup>2</sup>or Annual Deductible] responsibility you may have.]

Group [Para] Include when group chooses a plan with an annual DME limit of more than \$1,000. When this option is selected, the Must You Notify Us? column should read "Yes for items more than \$1,000." If a group chooses a plan with an annual DME limit of \$1,000 or less per year, remove the entire notification requirement language and select "No" in the "Must You Notify Us?" column.

**[Notify Us]**

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

Please remember that for Non-Network Benefits you must notify us before obtaining any single item of Durable Medical Equipment that costs more than \$1,000 (either purchase price or cumulative rental of a single item). If you don't notify us, you will be responsible for paying all charges and no Benefits will be paid.]]

**[Home Health Care described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

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

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

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home.

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

<u>[Network]</u> [No]	[ \$0 - 50 ] per visit [[ 0 - 50 ] %] [No Copayment] [ <sup>2</sup> Your Copayment will range between \$[ 0 - 50 ] per visit]	[Yes][No]	[Not Applicable] [Yes][No]
<u>[Non-Network]</u> [Yes]	[ 0 - 50 ] %	[Yes][No]	[Yes][No]

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• It is ordered by a Physician.</li> <li>• 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.</li> <li>• It requires clinical training in order to be delivered safely and effectively.</li> <li>• It is not Custodial Care.</li> </ul> <p>We will decide if skilled care is required 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.</p>				
Group [Para]	Include when group chooses to limit benefit.			
Group [text]	<sup>1</sup> Insert benefit limit selected by group. Standard is 60 visits.			
<p>[Any combination of Network and Non-Network Benefits is limited to [140 - 200] visits per [calendar][Policy] year. One visit equals four hours of skilled care services.]</p>				
Group [text]	<sup>1</sup> When the benefit plan design is to reduce benefits by one-half, insert a number that is one-half of the non-network benefit level (i.e. if the out of			

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>Group [text] network copayment is 20%, the benefit level is 80% and the number to insert here is 40%. <sup>2</sup>When the benefit plan design is to reduce benefit to 50%, insert 50%.</p>	<b>Notify Us</b>			
<p>Group [text] <sup>2</sup>Include if Benefit design includes a variable Copayment for Network Benefits depending upon the Network provider selected.</p>	<p>Please remember that for Non-Network Benefits you must notify us five business days before receiving services. If you don't notify us, Benefits will be reduced to [<sup>1-2</sup>25-50%] of Eligible Expenses.</p> <p><b>[<sup>2</sup>For Network Benefits, the Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]]</b></p>			

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*[Hospital - Inpatient Stay described in Section 1: (What's Covered - Benefits) is replaced with the following:]*

**[Benefit Information]**

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Hospital - Inpatient Stay]</b> Inpatient Stay in a Hospital. Benefits are available for:</p> <ul style="list-style-type: none"> <li>Supplies and non-Physician services received during the Inpatient Stay.</li> <li>Room and board in a Semi-private Room (a room with two or more beds).</li> </ul> <p>Admin. [text] <sup>1</sup>Include when facility-based Physicians are paid depending upon Network status and not as part of the facility charge.</p> <p>Benefits for Physician services <sup>1</sup>(including facility-based Physician services) are described under <i>Professional Fees for Surgical and Medical Services</i>.</p>	<p><b>[Network]</b> [No]</p>	<p>[[0 - 50]%] [\$[0 - 25,000] per Inpatient Stay] [\$[0 - 1,000] per day] [\$[0 - 1,000] per day to a maximum of \$[0 - 5,000] per Inpatient Stay] [No Copayment] <sup>3</sup>\$Your Copayment will range between \$[0 - 1,200] per day[, to a maximum of 4 days].]</p>	<p>[Yes] [No]</p>	<p>[Not Applicable] [Yes][No]</p>
<p style="text-align: center;"><b>Notify Us</b></p> <p>Please remember that for Non-Network Benefits you must notify us as follows:</p> <ul style="list-style-type: none"> <li>For elective admissions: five business days before admission.</li> <li>For non-elective admissions: within one business day or the same day of admission.</li> </ul>	<p><b>[Non-Network]</b> Yes]</p>	<p>[0 - 50]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<ul style="list-style-type: none"> <li>For Emergency admissions: within one business day or the same day of admission, or as soon as is reasonably possible.</li> </ul>				
Group [text] <sup>1</sup> When the benefit plan design is to reduce benefits by one-half, insert a number that is one-half of the non-network benefit level (i.e. if the out of network copayment is 20%, the benefit level is 80% and the number to insert here is 40%).				
Group [text] <sup>2</sup> When the benefit plan design is to reduce benefit to 50%, insert 50%.				
If you don't notify us, Benefits will be reduced to [ <sup>1-2</sup> 25-50%] of Eligible Expenses.				
Group [text] <sup>3</sup> Include if Benefit design includes a variable Copayment for Network Benefits depending upon the Network provider selected.				
<b>[<sup>3</sup> For Network Benefits, the Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]]</b>				

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**[Outpatient Surgery, Diagnostic and Therapeutic Services described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Outpatient Surgery, Diagnostic and Therapeutic Services]</b></p> <p><b><i>Outpatient Surgery</i></b> Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>Admin. [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.</p> <p>Admin. [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.</p> <p>Benefits under this section include only the facility charge and the charge for <sup>1</sup>required Hospital-based professional services, supplies and equipment. Benefits for the surgeons fees <sup>2</sup>and facility-based Physician's fees related to outpatient surgery are described under <i>Professional Fees for Surgical and Medical Services</i>.</p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.</p>	<p><b>[Network]</b> [No]</p>	<p>[\$[0 - 1,000] per surgical procedure] [[0 - 50]% ] [No Copayment] <sup>1</sup>Your Copayment will range between \$[0 - 3,000] per surgical procedure]</p>	<p>[Yes] [No]</p>	<p>[Not Applicable] [Yes][No]</p>
<p>Group [text] <sup>1</sup>Include if Benefit design includes a variable Copayment for Network</p>	<p><b>[Non-Network]</b> [No]</p>	<p>[[0 - 50]%]</p>	<p>[Yes][No]</p>	<p>[Yes][No]</p>

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
Benefits depending upon the Network provider selected.				
<p><b>[<sup>1</sup> For Network Benefits, the Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]</b></p>				
<p><b>Outpatient Diagnostic Services</b> Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:</p>	<p><b>[Network]</b> [No]</p>	<p><i>For lab and radiology/Xray:</i> [\$[0 - 1,000] per test] [[0 - 50]% ] [No Copayment]</p>	<p>[Yes][No]</p>	<p>[Not Applicable] [Yes][No]</p>
<ul style="list-style-type: none"> <li>• Lab and radiology/X-ray.</li> <li>• Mammography testing.</li> </ul>		<p><i>For mammography testing:</i> [\$[0 - 1,000] per test] [[0 - 50]% ] [No Copayment]</p>	<p>Yes][No]</p>	<p>[Not Applicable] [Yes][No]</p>
<p>Admin. [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.</p> <p>Admin. [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.</p>				
<p>Benefits under this section include the facility charge, [<sup>1</sup>and] the charge for required services, supplies and equipment<sup>[1]</sup>, and all related professional fees]. [<sup>2</sup>Benefits for facility-based Physician's fees related to these services are described under <i>Professional Fees for Surgical and Medical Services.</i>]</p>	<p><b>[Non-Network]</b> [No]</p>			
<p>When these services are performed in a Physician's office, Benefits</p>				
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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>are described under <i>Physician's Office Services</i> below.</p> <p>This section does not include Benefits for CT scans, Pet scans, MRIs, or nuclear medicine, which are described immediately below.</p>		<p>[0 - 50]% [No Benefits for preventive care.]</p>	<p>[Yes][No]</p>	<p>[Yes][No]</p>
<p><b><i>Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine</i></b></p> <p>Covered Health Services for CT scans, Pet scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>Admin. [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.</p> <p>Admin. [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.</p>	<p><b><u>[Network]</u></b> [No] [Yes]</p>	<p>[\$[0 - 1,000] per test [[0 - 50]% ] [No Copayment <sup>1</sup>Your Copayment will range between \$[0 - 3,000] per test]</p>	<p>[Yes][No]</p>	<p>[Not Applicable] [Yes][No]</p>
<p>Benefits under this section include the facility charge, <sup>1</sup>and the charge for required services, supplies and equipment<sup>1</sup>, and all related professional fees]. <sup>2</sup>Benefits for facility-based Physician's fees related to these services are described under <i>Professional Fees for Surgical and Medical Services.</i></p>	<p><b><u>[Non-Network]</u></b> [No] [Yes]</p>	<p>[0 - 50]%</p>	<p>[Yes][No]</p>	<p>[Yes][No]</p>
<p>Group [Para] Include text and select yes under "Must you notify us" if notification is required. Option included for requiring notification by the Covered Person for Network Benefits - if this is required, remove the bracketed "for Non-Network Benefits" language.</p> <p>Group [text] <sup>1</sup>When the benefit plan design is to reduce benefits by one-half, insert a number that is one-half of the benefit level (i.e. if the copayment is 20%, the</p>				

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>benefit level is 80% and the number to insert here is 40%.) Group [text] <sup>2</sup>When the benefit plan design is to reduce benefit to 50%, insert 50%.</p>	<b>[Notify Us]</b>			
<p>[Please remember that [for Non-Network Benefits] you must notify us before receiving these services. If you don't notify us, Benefits will be reduced to [<sup>1-2</sup>25-50%] of Eligible Expenses.]</p>				
<p>Group [text] <sup>1</sup>Include if Benefit design includes a variable Copayment for Network Benefits depending upon the Network provider selected.</p>				
<p><b>[<sup>1</sup> For Network Benefits, the Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]</b></p>				
<p><b><i>Outpatient Therapeutic Treatments</i></b></p>				
<p>Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.</p>	<b>[Network]</b> [No]	<p>[\$[0 - 1,000] per treatment] [[0 - 50]% ] [No Copayment]</p>	[Yes][No]	<p>[Not Applicable] [Yes][No]</p>
<p>Admin. [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.</p>				
<p>Admin. [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are</p>				

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p style="text-align: center;">paid according to Network status.</p> <p>Benefits under this section include the facility charge, <sup>[1]</sup>and the charge for required services, supplies and equipment<sup>[1]</sup>, and all related professional fees]. <sup>[2]</sup>Benefits for facility-based Physician's fees related to these services are described under <i>Professional Fees for Surgical and Medical Services.</i></p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.]</p>	<p style="text-align: center;"><u>[Non-Network]</u> [No]</p>	<p style="text-align: center;">[0 - 50]%</p>	<p style="text-align: center;">[Yes][No]</p>	<p style="text-align: center;">[Yes][No]</p>

**[Physicians Office Services described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Physician's Office Services]</b> Covered Health Services received in a Physician's office including:</p> <ul style="list-style-type: none"> <li>• Diagnosis and treatment of a Sickness or Injury.</li> <li>• Preventive medical care.</li> </ul>	<p style="text-align: center;"><u>[Network]</u> [No]</p>	<p style="text-align: center;">[[\$5 - 75] per visit] [No Copayment applies when no Physician charge</p>	<p style="text-align: center;">[Yes][No]</p>	<p style="text-align: center;">[Not Applicable] [Yes. Prostate Cancer Screenings not</p>

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<ul style="list-style-type: none"> <li>• Voluntary family planning.</li> <li>• Routine physical examinations.</li> <li>• Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See <i>Eye Examinations</i> earlier in this section.)</li> <li>• Well-baby and well-child care. Care shall include 20 visits at approximately the following age intervals: Birth, 2 Weeks, 2 Months, 4 Months, 6 Months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years and 18 years.</li> <li>• Immunizations. Please Note: No Copayment, Coinsurance or Deductible will be applicable to Children’s Immunization Services.</li> </ul>		<p>is assessed.]] [[0 - 50%] [No Copayment] [<sup>1</sup>Your Copayment will range between \$[0 – 75] per visit [ \$[5 - 75] per visit], except that the Copayment for a Specialist Physician is [ \$[5 – 75] per visit [No Copayment applies when no Physician charge is assessed.]</p>		<p>subject to Annual Deductible.] [No]</p>
<p><b>State Mandate</b></p>	<p><b>[Non-Network]</b> [No]</p>	<p>[0 - 50%] [No Benefits for preventive care, except for children under the age of 19.]</p>	<p>[Yes][No]</p>	<p>[Yes. Prostate Cancer Screenings not subject to Annual Deductible.] [No]</p>
<p>Admin. [text] <sup>1</sup>Include if Benefit design includes a variable Copayment for Network Benefits depending upon the Network provider selected.</p>	<p><b>[<sup>1</sup> For Network Benefits, the Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your</b></p>			

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

*ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]]*

**[Professional Fees for Surgical and Medical Services described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
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**[Professional Fees for Surgical and Medical Services**

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

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.]

<u>[Network]</u> [No]	[[0 - 50]%] [No Copayment]	[Yes] [No]	[Not Applicable] [Yes][No]
<u>[Non-Network]</u> [No]	[0 - 50]%]	[Yes][No]	[Yes][No]

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**[Prosthetic Devices described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Prosthetic Devices]</b> External prosthetic devices that replace a limb or an external body part, limited to:</p>	<p><b>[Network]</b> [No]</p>	<p>[[0 - 50] %] [No Copayment]</p>	<p>[Yes] [No]</p>	<p>[Not Applicable] [Yes][No]</p>
<ul style="list-style-type: none"> <li>• Artificial arms, legs, feet and hands.</li> <li>• Artificial eyes, ears and noses.</li> <li>• 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.</li> </ul>	<p><b>[Non-Network]</b> [No]</p>	<p>[0 - 50] %</p>	<p>[Yes] [No]</p>	<p>[Yes][No]</p>

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.

Group [text] <sup>1</sup>Include when group chooses a plan with a Prosthetic purchase every two or more years. The standard is once every three years.  
Group [text] <sup>2</sup>Include when group chooses a plan with a Prosthetic purchase of once every year.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic

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**[Description of Covered Health Service]**

**[Must You Notify Us?]**

**[Your Copayment Amount]**  
% Copayments are based on a percent of Eligible Expenses]

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

**[Do You Need to Meet Annual Deductible?]**

device every [1two-five] [calendar] [Policy] [1years][2year].

Group [Para]	Include when group chooses to limit benefit.
Group [text]	1Insert benefit limit selected by group. Standard options are \$2,500 and \$5,000.
Group [text]	2Include if Annual Deductible provision applies.

[Except for items required by the Women's Health and Cancer Rights Act of 1998, any combination of Network and Non-Network Benefits for prosthetic devices is limited to [1\$2,500-\$100,000] per [calendar] [Policy] year. This limit applies to the total amount that we will pay for the prosthetics, and does not include any Copayment [2or Annual Deductible] responsibility you may have.

Once this Benefit limit is reached, no additional Benefits are available except for items required by the Women's Health and Cancer Rights Act of 1998.]

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**[Rehabilitation Services - Outpatient Therapy described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Rehabilitation Services - Outpatient Therapy]</b></p>	<p><b>[Network]</b> [No]</p>	<p>[\$5 - 75] per visit [[0 - 50]%] [No Copayment] [<sup>2</sup>Your Copayment will range between \$[0 - 75] per visit]</p>	<p>[Yes] [No]</p>	<p>[Not Applicable] [Yes][No]</p>
<p>Short-term outpatient rehabilitation services for:</p>				
<ul style="list-style-type: none"> <li>• Physical therapy.</li> <li>• Occupational therapy.</li> <li>• Speech therapy.</li> <li>• Pulmonary rehabilitation therapy.</li> <li>• Cardiac rehabilitation therapy.</li> </ul>	<p><b>[Non-Network]</b> [No]</p>	<p>[0 - 50]%</p>	<p>[Yes] [No]</p>	<p>[Yes][No]</p>

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.

Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment.

Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury,

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**[Description of  
Covered Health Service]**

**[Must  
You  
Notify Us?]**

**[Your Copayment  
Amount  
% Copayments are  
based on a percent of  
Eligible Expenses]**

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

**[Do You Need  
to Meet Annual  
Deductible?]**

stroke or a Congenital Anomaly.

Group [Para]	Include when group chooses to limit benefit.
Group [text]	<sup>1</sup> Insert benefit limit selected by group. Standard is 20 visits for each, except that standard for cardiac therapy is 36 visits.

[Any combination of Network and Non-Network Benefits is limited as follows:

- [<sup>1</sup>10-100] visits of physical therapy per [calendar][Policy] year.
- [<sup>1</sup>10-100] visits of occupational therapy per [calendar][Policy] year.
- [<sup>1</sup>10-100] visits of speech therapy per [calendar][Policy] year.
- [<sup>1</sup>10-100] visits of pulmonary rehabilitation therapy per [calendar][Policy] year.
- [<sup>1</sup>10-100] visits of cardiac rehabilitation therapy per [calendar][Policy] year.]

Group [text]	<sup>2</sup> Include if Benefit design includes a variable Copayment for Network Benefits depending upon the Network provider selected.
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**[<sup>2</sup>For Network Benefits, the Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]]**

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## [Section 2: What's Not Covered - Exclusions]

*[Section 2 is modified by replacing exclusion #3 under Medical Supplies and Appliances with the following exclusion:]*

### **[Medical Supplies and Appliances]**

- [3. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces).]

*[Section 2 is modified by replacing exclusion #3 under Mental Health/Substance Abuse with the following exclusion:]*

### **[Mental Health/Substance Abuse]**

- [3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.]

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## [Section 3: Description of Network and Non-Network Benefits]

*[The introductory portion of the Network Benefits section in (Section 3: Description of Network and Non-Network Benefits) is replaced with the following:]*

### [Network Benefits]

[Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services which are:

- Provided by or under the direction of 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.
- Emergency Health Services.

Admin. [text]

<sup>1</sup>Include text if the plan design supports paying non-network benefits a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist).

<sup>1</sup>Covered Health Services provided in a Network facility by a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist) will be paid as Non-Network Benefits.]]

*[Designated Facilities and Other Providers in (Section 3: Description of Network and Non-Network Benefits) is replaced with the following:]*

### [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 other provider chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a non-Network facility or provider.

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 or other provider chosen by us.

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You or your Network Physician must notify us of special service needs (including, but not limited to, transplants or cancer treatment) that might warrant referral to a Designated Facility or non-Network facility or provider. 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.]

***[The introductory portion of the Non-Network Benefits section in (Section 3: Description of Network and Non-Network Benefits) is replaced with the following:]***

### **[Non-Network Benefits]**

[Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services which are any of the following:

- Provided by a non-Network Physician or other non-Network provider.
- Provided at a non-Network facility.

Admin. [text] <sup>1</sup>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).

- <sup>1</sup>[Non-Network Benefits include Covered Health Services that are provided by a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist) at a Network facility.]

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Admin. [text] <sup>1</sup>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 <sup>1</sup>[through our [Shared Savings Program]] to providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, and if your Copayment is expressed as a percentage of Eligible Expenses for Non-Network Benefits, that percentage 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 when you receive Covered Health Services <sup>1</sup>[from [Shared Savings Program] providers than] from other non-Network providers, because the Eligible Expense may be a lesser amount.]

***[Emergency Health Services in (Section 3: Description of Network and Non-Network Benefits) is replaced with the following:]***

### **[Emergency Health Services]**

[We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network provider.

If you are confined in a non-Network Hospital after you receive Emergency Health Services, we must be notified within one business day or on the same day of admission if reasonably possible. We may

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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, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.]

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## [Section 5: How to File a Claim]

**[*Payment of Benefits in (Section 5: How to File a Claim) is replaced with the following:*]**

**[*Payment of Benefits*]**

Admin. [text] <sup>1</sup>Include the following provision and delete option #2 below if assignment of benefits is agreed to.

<sup>1</sup>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.]

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

<sup>2</sup>You may not assign your Benefits under the Policy to a non-Network provider without our consent. We may, however, in our discretion, pay a non-Network provider directly for services rendered to you.]

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## Section 9: General Legal Provisions

**[Subrogation and Reimbursement is replaced with the following:]**

### **[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 of Coverage, 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,

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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.

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- That we have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the event that you recover from a Third Party, we agree to pay our share of the reasonable costs of collection and attorney fees in the proportion we benefit from the recovery.
- 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.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors for 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.]

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## [Section 10: Glossary of Defined Terms]

**[The definition of Alternate Facility is replaced with the following:]**

**[Alternate Facility]** - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.]

Group [text] <sup>1</sup>include text as standard for groups that purchase MH/SA coverage. Delete text if group has not purchased MH/SA benefits

<sup>1</sup>An Alternate Facility may also provide Mental Health Services or Substance Abuse Services on an outpatient or inpatient basis.]

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

**[The definition of Designated Facility is replaced with the following:]**

**[Designated Facility]** - a facility that has entered into an agreement on behalf of the facility and its affiliated staff 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.]

**[The definition of Eligible Expenses is replaced with the following:]**

**[Eligible Expenses]** - the amount we will pay for Covered Health Services, incurred while the Policy is in effect, are determined as stated below:

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

- When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers as a result of an Emergency or as otherwise arranged by

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us, Eligible Expenses are billed charges unless a lower amount is negotiated.

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

Admin. [text] Include the provisions that apply for determining Eligible Expenses for Non-Network Benefits.

- When Covered Health Services are received from non-Network providers, Eligible Expenses are determined, [at our discretion,] based on [ the lesser of]:
  - [[Available data resources of competitive fees in that geographic area.]
  - [Our most commonly used contracted fee(s) with Network providers for the same or similar service within the geographic market] [or] [the amount determined by us which Network providers have agreed to accept as payment in full.]
  - [Fee(s) that are negotiated with the provider.]
  - [A percentage of the published rates allowed by Medicare for the same or similar service [within the geographic market].]
  - [A percentage of the published rates allowed by CMS for the same or similar service [within the geographic market].]
  - [A percentage of the published rates allowed by Medicare in [name of county, name of state] for the same or similar service.]
  - [A percentage of the published rates allowed by CMS in [name of county, name of state] for the same or similar service.]
  - [\_\_% of the billed charge.]

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— [A fee schedule that we develop.]

- When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider.

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.]

**[The definition of Network is replaced with the following:]**

Admin. [text] <sup>1</sup>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.

[To continue reading, go to left column on next page.]

**[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 **[<sup>1</sup>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.]

**[The definition of Network Benefits is replaced with the following:]**

**[Network Benefits]** - Benefits for Covered Health Services that are provided by or under the direction of 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 Emergency Health Services.]

Admin. [text] <sup>1</sup>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).

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

**[The definition of Non-Network Benefits is replaced with the following:]**

**[Non-Network Benefits]** - Benefits for 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. **[<sup>1</sup>Covered Health Services provided in a Network facility by a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist) will be paid as Non-Network Benefits.]]**

**[The definition of Out-of-Pocket Maximum is replaced with the following:]**

Group [Para] Include if group chooses a plan design that includes an Out-of-Pocket Maximum provision.

Group [text] <sup>1</sup>Include if Annual Deductible provision applies and if the OOPM includes the Annual Deductible.

**[Out-of-Pocket Maximum]** - the maximum amount of **[<sup>1</sup>Annual Deductible and]** Copayments you pay every **[calendar] [Policy]** year. If you use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once you reach the Out-of-Pocket Maximum for Network Benefits, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that **[calendar] [Policy]** year. Once you reach the Out-of-Pocket Maximum for Non-Network Benefits, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that **[calendar] [Policy]** year. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in (Section 1: What's Covered--Benefits) and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.

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The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services.
- Copayments for Covered Health Services available by an optional Rider.
- The amount of any reduced Benefits if you don't notify us as described in (Section 1: What's Covered--Benefits) under the *Must You Notify Us?* column.
- Charges that exceed Eligible Expenses.
- Any Copayments for Covered Health Services in Section 1: What's Covered--Benefits) that do not apply to the Out-of-Pocket Maximum.

Group [text] <sup>2</sup>Include if an Annual Deductible provision applies, but is not included in the OOPM.

- [<sup>2</sup>The Annual Deductible.]

Even when the Out-of-Pocket Maximum has been reached, you will still be required to pay:

- Any charges for non-Covered Health Services.
- Charges that exceed Eligible Expenses.
- The amount of any reduced Benefits if you don't notify us as described in (Section 1: What's Covered - Benefits) under the *Must You Notify Us?* column.
- Copayments for Covered Health Services available by an optional Rider.

- Copayments for Covered Health Services in (Section 1: What's Covered - Benefits) that are subject to Copayments that do not apply to the Out-of-Pocket Maximum.]

**[The following definition of *Shared Savings Program* is added:]**

Admin. [text] <sup>1</sup>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.

[<sup>1</sup>*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, 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 Copayments calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.]

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# 2002 Amendment to the Certificate of Coverage

*The Certificate of Coverage is modified as described in this Amendment.*

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## [Section 1: What's Covered - Benefits]

***["Accessing Benefits" in (Section 1: What's Covered - Benefits) is replaced with the following:]***

### **[Accessing Benefits]**

Admin. [text] <sup>1</sup>Include text if the plan design supports denying benefits for any service provided by a non-network facility-based Physician.

[To obtain Benefits, you must select a Primary Physician who will provide or coordinate all of the Covered Health Services you receive. Not all Covered Health Services require a referral from your Primary Physician. For facility services, Benefits are available for Covered Health Services that are provided at a Network facility under the direction of either your Primary Physician or other Network Physician.

[<sup>1</sup> There are no Benefits for Covered Health Services provided in a Network facility by a non-Network facility-based Physician (a non-

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

Network anesthesiologist, radiologist, or pathologist).]

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.

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

- Covered Health Services are received while the group Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in (Section 8: When Coverage Ends) occurs.

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- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.]

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**[The following information is added to the Payment Information table in (Section 1: What's Covered - Benefits):]**

**[Payment Information]**

**Plan [Para]** Include if a separate deductible applies to Mental Health Services, Substance Abuse Services, or a combination of both.  
**Plan [text]** <sup>1</sup>Include references to describe if this deductible applies only to Mental Health Services, only to Substance Abuse Services, or to a combination of both.

**[The following payment information applies to Benefits for [<sup>1</sup>Mental Health Services] [<sup>1</sup>and] [<sup>1</sup>Substance Abuse Services].]**

Payment Term	Description	Amounts
<p><b>[<sup>1</sup>Mental Health Services] [<sup>1</sup>and] [<sup>1</sup>Substance Abuse Services] Deductible]</b></p>	<p>Plan [text] <sup>1</sup>Include references to describe if this deductible applies only to Mental Health Services, only to Substance Abuse Services, or to a combination of both.</p> <p>[The amount you must pay for Covered [<sup>1</sup>Mental Health Services] [<sup>1</sup>and] [<sup>1</sup>Substance Abuse Services] before you are eligible to receive Benefits.]</p>	<p>[\$<sup>1</sup>0 - 25,000] per Covered Person per [calendar] [Policy] year.]</p>

**[The following information is added to the Payment Information table in (Section 1: What's Covered - Benefits):]**

**[Payment Information]**

**Plan [Para]** Include if a separate OOPM applies to Mental Health Services, Substance Abuse Services, or a combination of both.  
**Plan [text]** <sup>1</sup>Include references to describe if this OOPM applies only to Mental Health Services, only to Substance Abuse Services, or to a combination of both.

**[The following payment information applies to Benefits for <sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services].]**

Payment Term	Description	Amounts	
<b>[<sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services] Out-of-Pocket Maximum ]</b>	Plan [text] <sup>1</sup> Include references to describe if this OOPM feature applies only to Mental Health Services, only to Substance Abuse Services, or to a combination of both.	Group [text] <sup>1</sup> Insert appropriate amount of OOPM. [\$ <sup>1</sup> 0 - 25,000] per Covered Person per [calendar][Policy] year.]	
	Group [text] <sup>2</sup> include when overall OOPM provision applies.	<b>Plan [Para]</b> Include when this OOPM provision and either the Annual Deductible provision or the MH/SA deductible provisions apply.	
	[The maximum you pay, out of your pocket, in a [calendar][Policy] year for Copayments for <sup>1</sup> Mental Health Services] <sup>1</sup> and] <sup>1</sup> Substance Abuse Services]. <sup>2</sup> This amount is not included in the overall Out-of-Pocket Maximum stated in your Certificate.]]	Plan [text] <sup>1</sup> Include references to describe if this OOPM feature applies only to Mental Health Services, only to Substance Abuse Services, or to a combination of both.	[This <sup>1</sup> Mental Health Services] <sup>1</sup> and] <sup>1</sup> Substance Abuse Services] Out-of-Pocket Maximum does not include <sup>2</sup> the Annual Deductible or] the <sup>1</sup> Mental Health Services] <sup>1</sup> and] <sup>1</sup> Substance Abuse Services] Deductible.]
		Group [text] <sup>2</sup> include if an Annual Deductible provision applies.	

**[Durable Medical Equipment described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Durable Medical Equipment]</b> Durable Medical Equipment that meets each of the following criteria:</p> <ul style="list-style-type: none"> <li>• Ordered or provided by a Physician for outpatient use.</li> <li>• Used for medical purposes.</li> <li>• Not consumable or disposable.</li> <li>• Not of use to a person in the absence of a disease or disability.</li> </ul> <p>If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment.</p> <p>Examples of Durable Medical Equipment include:</p> <ul style="list-style-type: none"> <li>• Equipment to assist mobility, such as a standard wheelchair.</li> <li>• A standard Hospital-type bed.</li> <li>• Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).</li> <li>• Delivery pumps for tube feedings (including tubing and connectors).</li> </ul>	<p>[[0 - 50]%] [No Copayment]</p>	<p>[Yes] [No]</p>	<p>[Yes][No]</p>

[Description of Covered Health Service]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<ul style="list-style-type: none"> <li>• 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. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.</li> <li>• 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).</li> </ul>			
<p>Group [text] <sup>1</sup>Include when group chooses a plan with DME purchase of every two-five years. The standard is once every three years.</p>			
<p>Group [text] <sup>2</sup>Include when group chooses a plan with DME purchase of once every year.</p>			
<p>We provide Benefits only for a single purchase (including repair/ replacement) of a type of Durable Medical Equipment once every [<sup>1</sup>two-five] [calendar] [Policy] [<sup>1</sup>years][<sup>2</sup>year].</p>			
<p>We will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor we identify.</p>			
<p>Group [Para] Include when a group chooses to limit benefit.</p>			
<p>Group [text] <sup>1</sup>Insert benefit limit selected by group. Standard options are \$750, \$1,000, \$1,500, \$2,000 or \$2,500.</p>			
<p>Group [text] <sup>2</sup>Include if Annual Deductible provision applies.</p>			
<p>[Benefits for Durable Medical Equipment are limited to [<sup>1</sup>\$750 - \$100,000] per [calendar] [Policy] year. This limit applies to the total</p>			

**[Description of Covered Health Service]**

**[Your Copayment Amount]**

% Copayments are based on a percent of Eligible Expenses]

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

**[Do You Need to Meet Annual Deductible?]**

amount that we will pay for the Durable Medical Equipment, and does not include any Copayment [2or Annual Deductible] responsibility you may have.]]

**[Home Health Care described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

**[Description of Covered Health Service]**

**[Your Copayment Amount]**

% Copayments are based on a percent of Eligible Expenses]

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

**[Do You Need to Meet Annual Deductible?]**

**[Home Health Care]**

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

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home.

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent 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

[\$[0 - 50] per visit] [[0 - 50]%]  
[No Copayment] [2Your Copayment will range between \$[0 - 50] per visit]

[Yes][No]

[Yes][No]

**[Description of Covered Health Service]**

**[Your Copayment Amount**

% Copayments are based on a percent of Eligible Expenses]

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

**[Do You Need to Meet Annual Deductible?]**

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 decide if skilled care is required 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.

Group [Para] Include when group chooses to limit benefit.

Group [text] <sup>1</sup>Insert benefit limit selected by group. Standard is 60 visits.

[Benefits are limited to [<sup>1</sup>40 - 200] visits per [calendar][Policy] year. One visit equals four hours of skilled care services.]

Group [text] <sup>2</sup>Include if Benefit design includes a variable Copayment depending upon the Network provider selected.

**[<sup>2</sup>The Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]]**

*[Hospital - Inpatient Stay described in Section 1: (What's Covered - Benefits) is replaced with the following:]*

**[Benefit Information]**

[Description of Covered Health Service]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Hospital - Inpatient Stay]</b>                      Inpatient Stay in a Hospital. Benefits are available for:</p> <ul style="list-style-type: none"> <li>Supplies and non-Physician services received during the Inpatient Stay.</li> <li>Room and board in a Semi-private Room (a room with two or more beds).</li> </ul> <p>Admin. [text] <sup>1</sup>Include when facility-based Physicians are paid depending upon Network status and not as part of the facility charge.</p> <p>Benefits for Physician services <sup>1</sup>(including facility-based Physician services) are described under <i>Professional Fees for Surgical and Medical Services</i>.</p> <p>Group [text] <sup>3</sup>Include if Benefit design includes a variable Copayment depending upon the Network provider selected.</p> <p><sup>2</sup><i>The Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]]</i></p>	<p>[[0 - 50]%]                      [0 - 25,000] per Inpatient Stay]                      [0 - 1,000] per day]                      [0 - 1,000] per day to a maximum of \$[0 - 5,000] per Inpatient Stay]                      [No Copayment]                      [Your Copayment will range between \$[0 - 1,200] per day[, to a maximum of 4 days].]</p>	<p>[Yes] [No]</p>	<p>[Yes][No]</p>

**[Outpatient Surgery, Diagnostic and Therapeutic Services described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Outpatient Surgery, Diagnostic and Therapeutic Services</b></p> <p><b><i>Outpatient Surgery</i></b> Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>Admin. [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge. Admin. [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.</p> <p>Benefits under this section include only the facility charge and the charge for <sup>1</sup>required Hospital-based professional services, supplies and equipment. Benefits for the surgeons fees <sup>2</sup>and facility-based Physician's fees related to outpatient surgery are described under <i>Professional Fees for Surgical and Medical Services</i>.</p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.</p> <p>Group [text] <sup>1</sup>Include if Benefit design includes a variable Copayment depending upon the Network provider selected.</p> <p><b>[<sup>1</sup> The Copayment that applies to this Benefit is based on</b></p>	<p>[\$[0 - 1,000] per surgical procedure] [[0 - 50]% ] [No Copayment] <sup>1</sup>Your Copayment will range between \$[0 - 3,000] per surgical procedure]</p>	<p>[Yes] [No]</p>	<p>[Yes][No]</p>

[Description of Covered Health Service]

[Your Copayment Amount

% Copayments are based on a percent of Eligible Expenses]

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

[Do You Need to Meet Annual Deductible?]

*which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]*

**Outpatient Diagnostic Services**

Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:

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

Admin. [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.  
 Admin. [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.

Benefits under this section include the facility charge, <sup>1</sup>and the charge for required services, supplies and equipment<sup>1</sup>, and all related professional fees]. <sup>2</sup>Benefits for facility-based Physician's fees related to these services are described under *Professional Fees for Surgical and Medical Services.*

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

This section does not include Benefits for CT scans, Pet scans, MRIs, or nuclear medicine, which are described immediately below.

*For lab and radiology/Xray:*

[\$[0 - 1,000] per test]  
 [[0 - 50]% ]  
 [No Copayment]

[Yes][No]

[Yes][No]

*For mammography testing:*

[\$[0 - 1,000] per test]  
 [[0 - 50]% ]  
 [No Copayment]

[Yes][No]

[Yes][No]

[

[Description of Covered Health Service]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b><i>Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine</i></b></p> <p>Covered Health Services for CT scans, Pet scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>Admin. [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.</p> <p>Admin. [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.</p> <p>Benefits under this section include the facility charge, <sup>1</sup>and the charge for required services, supplies and equipment<sup>1</sup>, and all related professional fees]. <sup>2</sup>Benefits for facility-based Physician's fees related to these services are described under <i>Professional Fees for Surgical and Medical Services</i>.</p> <p>Group [text] <sup>1</sup>Include if Benefit design includes a variable Copayment depending upon the Network provider selected.</p> <p><sup>1</sup><b><i>The Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.</i></b></p>	<p>[\$[0 - 1,000] per test [[0 - 50]% ] [No Copayment] <sup>1</sup>Your Copayment will range between \$[0 - 3,000] per test]</p>	<p>[Yes][No]</p>	<p>[Yes][No]</p>
<p><b><i>Outpatient Therapeutic Treatments</i></b></p> <p>Covered Health Services for therapeutic treatments received on an</p>	<p>[\$[0 - 1,000] per</p>	<p>[Yes][No]</p>	<p>[Yes][No]</p>

[Description of Covered Health Service]	[Your Copayment Amount]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.	treatment [[0 - 50]%] [No Copayment]		

Admin. [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.

Admin. [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.

Benefits under this section include the facility charge, <sup>1</sup>and the charge for required services, supplies and equipment<sup>1</sup>, and all related professional fees]. <sup>2</sup>Benefits for facility-based Physician's fees related to these services are described under *Professional Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.]

**[Physicians Office Services described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Your Copayment Amount]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<b>[Physician's Office Services</b>	[[ \$5 - 75] per	[Yes][No]	[Yes. Prostate

[Description of Covered Health Service]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
Covered Health Services received in a Physician's office including:	visit] [No Copayment applies when no Physician charge is assessed.]] [0 - 50%] [No Copayment] [ <sup>1</sup> Your Copayment will range between \$[0 - 75] per visit] [[\$[5 - 75] per visit], except that the Copayment for a Primary Physician office visit is [[\$[5 - 75] per visit. [No Copayment applies when no Physician charge is assessed.]]		Cancer Screenings not subject to Annual Deductible.] [No]
<ul style="list-style-type: none"> <li>• Diagnosis and treatment of a Sickness or Injury.</li> <li>• Preventive medical care.</li> <li>• Voluntary family planning.</li> <li>• Routine physical examinations.</li> <li>• Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See <i>Eye Examinations</i> earlier in this section.)</li> <li>• Well-baby and well-child care. Care shall include 20 visits at approximately the following age intervals: Birth, 2 Weeks, 2 Months, 4 Months, 6 Months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years and 18 years.</li> <li>• Immunizations. Please Note: No Copayment, Coinsurance or Deductible will be applicable to Children's Immunization Services.</li> </ul>			
<b>State Mandate</b>			
<ul style="list-style-type: none"> <li>• Prostate Cancer Screenings provided at minimum one (1) screening per [calendar][Policy] year for any male Covered Person forty (40) years of age or older.</li> </ul>			
<p><sup>1</sup>Include if Benefit design includes a variable Copayment depending upon the Network provider selected.</p>			
<p><b>[<sup>1</sup> The Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of</b></p>			

**[Description of Covered Health Service]**

**[Your Copayment Amount]**

% Copayments are based on a percent of Eligible Expenses]

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

**[Do You Need to Meet Annual Deductible?]**

*[Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]]*

**[Professional Fees for Surgical and Medical Services described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

**[Description of Covered Health Service]**

**[Your Copayment Amount]**

% Copayments are based on a percent of Eligible Expenses]

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

**[Do You Need to Meet Annual Deductible?]**

**[Professional Fees for Surgical and Medical Services]**

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

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.]

[[0 - 50]%]  
[No Copayment]

[Yes] [No]

[Yes][No]

**[Prosthetic Devices described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Prosthetic Devices]</b>                      External prosthetic devices that replace a limb or an external body part, limited to:</p> <ul style="list-style-type: none"> <li>• Artificial arms, legs, feet and hands.</li> <li>• Artificial eyes, ears and noses.</li> <li>• 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.</li> </ul>	<p>[[0 - 50] %]                      [No Copayment]</p>	<p>[Yes] [No]</p>	<p>[Not Applicable]                      [Yes][No]</p>

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.

Group [text] <sup>1</sup>Include when group chooses a plan with a Prosthetic purchase every two or more years. The standard is once every three years.

Group [text] <sup>2</sup>Include when group chooses a plan with a Prosthetic purchase of once every year.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every [<sup>1</sup>two-five] [calendar] [Policy] [<sup>1</sup>years][<sup>2</sup>year].

**[Description of Covered Health Service]**

**[Your Copayment Amount]**

% Copayments are based on a percent of Eligible Expenses]

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

**[Do You Need to Meet Annual Deductible?]**

Group [Para] Include when group chooses to limit benefit.  
 Group [text] <sup>1</sup>Insert benefit limit selected by group. Standard options are \$2,500 and \$5,000.  
 Group [text] <sup>2</sup>Include if Annual Deductible provision applies.

[Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to [<sup>1</sup>\$2,500-\$100,000] per [calendar] [Policy] year. This limit applies to the total amount that we will pay for the prosthetics, and does not include any Copayment [<sup>2</sup>or Annual Deductible] responsibility you may have.

Once this Benefit limit is reached, no additional Benefits are available except for items required by the Women's Health and Cancer Rights Act of 1998.]

**[Rehabilitation Services - Outpatient Therapy described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

**[Description of Covered Health Service]**

**[Your Copayment Amount]**

% Copayments are based on a percent of Eligible Expenses]

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

**[Do You Need to Meet Annual Deductible?]**

**[Rehabilitation Services - Outpatient Therapy]**

Short-term outpatient rehabilitation services for:

[\$[5 - 75] per visit]  
 [[0 - 50]%]  
 [No Copayment]  
 [<sup>2</sup>Your

[Yes] [No]

[Yes][No]

[Description of Covered Health Service]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<ul style="list-style-type: none"> <li>Physical therapy.</li> <li>Occupational therapy.</li> <li>Speech therapy.</li> <li>Pulmonary rehabilitation therapy.</li> <li>Cardiac rehabilitation therapy.</li> </ul> <p>Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.</p> <p>Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment.</p> <p>Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.</p>	<p>Copayment will range between \$[0 – 75] per visit]</p>		
<p>Group [Para]      Include when group chooses to limit benefit.            Group [text]      <sup>1</sup>Insert benefit limit selected by group. Standard is 20 visits for each, except that standard for cardiac therapy is 36 visits.</p>			
<p>[Benefits are limited as follows:</p>			
<ul style="list-style-type: none"> <li>[<sup>1</sup>10-100] visits of physical therapy per [calendar][Policy] year.</li> <li>[<sup>1</sup>10-100] visits of occupational therapy per [calendar][Policy] year.</li> <li>[<sup>1</sup>10-100] visits of speech therapy per [calendar][Policy] year.</li> <li>[<sup>1</sup>10-100] visits of pulmonary rehabilitation therapy per [calendar][Policy] year.</li> </ul>			

**[Description of Covered Health Service]**

**[Your Copayment Amount]**

% Copayments are based on a percent of Eligible Expenses]

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

**[Do You Need to Meet Annual Deductible?]**

- <sup>1</sup>[10-100] visits of cardiac rehabilitation therapy per [calendar][Policy] year.]

Group [text] <sup>2</sup>Include if Benefit design includes a variable Copayment depending upon the Network provider selected.

***[<sup>2</sup>The Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]]***

## [Section 2: What's Not Covered - Exclusions]

*[Section 2 is modified by replacing exclusion #3 under Medical Supplies and Appliances with the following exclusion:]*

### [Medical Supplies and Appliances]

- [3. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces).]

*[Section 2 is modified by replacing exclusion #3 under Mental Health/Substance Abuse with the following exclusion:]*

### [Mental Health/Substance Abuse]

- [3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.]

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

*[To continue reading, go to left column on next page.]*

## [Section 3: Obtaining Benefits]

*[The introductory portion of the Benefits section in (Section 3: Obtaining Benefits) is replaced with the following:]*

### [Benefits]

[Benefits are payable for Covered Health Services which are any of the following:

Admin. [text] <sup>1</sup>Include text if the plan design supports denying benefits for any service provided by a non-network facility-based Physician.

- Provided by or under the immediate direction of your Primary Physician.
- Provided by a Network Physician or other Network provider when the Covered Health Service does not require a referral from your Primary Physician (as identified for you by your Primary Physician.)
- For facility services, these are Benefits for Covered Health Services that are provided at a Network facility under the direction of either your Primary Physician or other Network Physician.
- Emergency Health Services.
- Urgent Care Center services received outside the Service Area.

Benefits are not payable for Covered Health Services that are provided by non-Network providers.

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

<sup>1</sup>Benefits are not available for Covered Health Services provided in a Network facility by a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist), unless the Covered Health Services are provided under the immediate direction of your Primary Physician.]]

*[Designated Facilities and Other Providers in (Section 3: Obtaining Benefits) is replaced with the following:]*

### *[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 other provider chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a non-Network facility or provider.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility or other provider chosen by us.

You or your Primary Physician or other Network Physician must notify us of special service needs (including, but not limited to, transplants or cancer treatment) that might warrant referral to a Designated Facility or non-Network facility or provider. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.]

*[To continue reading, go to left column on next page.]*

***[Emergency Health Services in (Section 3: Obtaining Benefits) is replaced with the following:]***

## **[Emergency Health Services]**

[We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

We provide Benefits for Emergency Health Services even if you do not have a referral from your Primary Physician. Whenever possible, you should contact your Primary Physician before receiving Emergency Health Services, and then seek care from the Network provider he or she designates.

Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network provider.

If you are confined in a non-Network Hospital after you receive Emergency Health Services, we must be notified within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be available.]

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

*[To continue reading, go to left column on next page.]*

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## Section 9: General Legal Provisions

**[Subrogation and Reimbursement is replaced with the following:]**

### **[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 of Coverage, 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,

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

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.

*[To continue reading, go to left column on next page.]*

UnitedHealthcare of Arkansas, Inc.

- That we have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the event that you recover from a Third Party, we agree to pay our share of the reasonable costs of collection and attorney fees in the proportion we benefit from the recovery.
- 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.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors for 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.]

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## [Section 10: Glossary of Defined Terms]

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

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**[The definition of Alternate Facility is replaced with the following:]**

**[Alternate Facility]** - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.]

Group [text] <sup>1</sup>Include text as standard for groups that purchase MH/SA coverage. Delete text if group has not purchased MH/SA benefits

<sup>1</sup>An Alternate Facility may also provide Mental Health Services or Substance Abuse Services on an outpatient or inpatient basis.]

**[The definition of Designated Facility is replaced with the following:]**

**[Designated Facility]** - a facility that has entered into an agreement on behalf of the facility and its affiliated staff 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.]

**[The definition of Eligible Expenses is replaced with the following:]**

**[Eligible Expenses]** - the amount we will pay for Covered Health Services, incurred while the Policy is in effect, are determined as stated below:

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

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated.

**[The definition of Network is replaced with the following:]**

**[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. 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.]

**[The definition of Out-of-Pocket Maximum is replaced with the following:]**

Group [Para] Include if group chooses a plan design that includes an Out-of-Pocket-Maximum provision.

*[To continue reading, go to left column on next page.]*

Group [text] <sup>1</sup>Include if Annual Deductible provision applies and if the OOPM includes the Annual Deductible.

**[*Out-of-Pocket Maximum*** - the maximum amount of [<sup>1</sup>Annual Deductible and] Copayments you pay every [calendar] [Policy] year. Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that [calendar] [Policy] year. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in (Section 1: What's Covered--Benefits) and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services.
- Copayments for Covered Health Services available by an optional Rider.
- Any Copayments for Covered Health Services in Section 1: What's Covered--Benefits) that do not apply to the Out-of-Pocket Maximum.

Group [text] <sup>2</sup>Include if an Annual Deductible provision applies, but is not included in the OOPM.

- [<sup>2</sup>The Annual Deductible.]

Even when the Out-of-Pocket Maximum has been reached, you will still be required to pay:

- Any charges for non-Covered Health Services.
- Copayments for Covered Health Services available by an optional Rider.

- Copayments for Covered Health Services in (Section 1: What's Covered - Benefits) that are subject to Copayments that do not apply to the Out-of-Pocket Maximum.]

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*[To continue reading, go to left column on next page.]*

# 2002 Amendment to the Certificate of Coverage

*The Certificate of Coverage is modified as described in this Amendment.*

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## [Section 1: What's Covered - Benefits]

**[*"Accessing Benefits" in (Section 1: What's Covered - Benefits) is replaced with the following:*]**

### **[Accessing Benefits]**

[You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits, you must select a Primary Physician who will provide or coordinate all of the Covered Health Services you receive. Not all Covered Health Services require a referral from your Primary Physician. For facility services, Network

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

Benefits apply to Covered Health Services that are provided at a Network facility under the direction of either a Network or non-Network Physician or other provider.

Admin. [text] <sup>1</sup>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).

<sup>1</sup>Covered Health Services provided in a Network facility by a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist) will be paid as Non-Network Benefits.]

You must show your identification card (ID card) every time you

*[To continue reading, go to left column on next page.]*

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UnitedHealthcare of Arkansas, Inc.  
[and]  
[United HealthCare Insurance Company]

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. For details about when Network Benefits apply, see (Section 3: Description of Network and Non-Network Benefits).

[Program] providers than] from other non-Network providers, because the Eligible Expense may be a lesser amount.]

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

- Covered Health Services are received while the group Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in (Section 8: When Coverage Ends) occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

Admin. [text] <sup>1</sup>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 [<sup>1</sup>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, and if your Copayment is expressed as a percentage of Eligible Expenses for Non-Network Benefits, that percentage 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 when you receive Covered Health Services [<sup>1</sup>from [Shared Savings

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**[The following information is added to the Payment Information table in (Section 1: What's Covered - Benefits):]**

**[Payment Information]**

**Plan [Para]** Include if a separate deductible applies to Mental Health Services, Substance Abuse Services, or a combination of both.  
**Plan [text]** <sup>1</sup>Include references to describe if this deductible applies only to Mental Health Services, only to Substance Abuse Services, or to a combination of both.

**[The following payment information applies to Benefits for <sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services].]**

Payment Term	Description	Amounts
<b>[<sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services] Deductible]</b>	Plan [text]	<p style="text-align: center;"><b>[<u>Network</u>]</b></p> <p><b>Group [Para]</b> Include when deductible provision applies to Network Benefits  <b>Group [text]</b> <sup>1</sup>Insert appropriate amount for deductible.  <b>[\$<sup>1</sup>0 - 25,000] per Covered Person per [calendar] [Policy] year.]</b></p> <p><b>Group [Para]</b> Include when deductible provision does not apply to Network Benefits.  <b>[This deductible provision does not apply]]</b></p> <p style="text-align: center;"><b>[<u>Non-Network</u>]</b></p> <p><b>Group [Para]</b> Include when deductible applies to Non-Network Benefits  <b>Group [text]</b> <sup>1</sup>Insert appropriate amount for deductible  <b>[\$<sup>1</sup>0 - 25,000] per Covered Person per [calendar] [Policy] year.]</b></p> <p><b>Group [Para]</b> Include when deductible provision does not apply to Non-Network Benefits.  <b>[This deductible provision does not apply.]]</b></p>
	Group [text]	
	<p><b>[The amount you must pay for Covered <sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services] before you are eligible to receive <sup>2</sup>Non-Network] Benefits.]</b></p>	

**[The following information is added to the Payment Information table in (Section 1: What's Covered - Benefits):]**

**[Payment Information]**

**Plan [Para]** Include if a separate OOPM applies to Mental Health Services, Substance Abuse Services, or a combination of both.  
**Plan [text]** <sup>1</sup>Include references to describe if this OOPM applies only to Mental Health Services, only to Substance Abuse Services, or to a combination of both.

**[The following payment information applies to Benefits for <sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services].]**

Payment Term	Description	Amounts
<p><b>[<sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services] Out-of-Pocket Maximum ]</b></p>	<p>Plan [text] <sup>1</sup>Include references to describe if this OOPM feature applies only to Mental Health Services, only to Substance Abuse Services, or to a combination of both.</p> <p>Group [text] <sup>2</sup>Include when overall OOPM provision applies.</p> <p><b>[The maximum you pay, out of your pocket, in a [calendar][Policy] year for Copayments for <sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services]. <sup>2</sup>This amount is not included in the overall Out-of-Pocket Maximum stated in your Certificate.]]</b></p>	<p><b>[<u>Network</u></b></p> <p><b>Group [Para]</b> Include when this OOPM provision applies to Network Benefits.</p> <p><b>Group [text]</b> <sup>1</sup>Insert appropriate amount of OOPM.  <b>[\$<sup>1</sup>0 - 25,000] per Covered Person per [calendar][Policy] year.]</b></p> <p><b>Plan [Para]</b> Include when this OOPM provision and either the Annual Deductible provision or the MH/SA deductible provisions apply for Network Benefits.</p> <p><b>Plan [text]</b> <sup>1</sup>Include references to describe if this OOPM feature applies only to Mental Health Services, only to Substance Abuse Services, or to a combination of both.</p> <p><b>Group [text]</b> <sup>2</sup>Include if an Annual Deductible provision applies to Network Benefits.  <b>[This <sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services] Out-of-Pocket Maximum does not include <sup>2</sup>the Annual Deductible or] the <sup>1</sup>Mental Health Services] <sup>1</sup>and] <sup>1</sup>Substance Abuse Services] Deductible.]</b></p> <p><b>Group [text]</b> Include if this OOPM provision does not apply to Network Benefits.  <b>[This out-of-pocket maximum provision does not apply.]]</b></p> <p style="text-align: center;"><b>[<u>Non-Network</u></b></p> <p><b>Group [Para]</b> Include when this OOPM provision applies to Non-Network Benefits.</p> <p><b>Group [text]</b> <sup>1</sup>Insert appropriate amount of OOPM.  <b>[\$<sup>1</sup>0 - 25,000] per Covered Person per [calendar][Policy] year.]</b></p> <p><b>Plan [Para]</b> Include when this OOPM provision and either the Annual Deductible provision or the MH/SA deductible provisions apply for Non-Network Benefits.</p> <p><b>Plan [text]</b> <sup>1</sup>Include references to describe if this OOPM feature applies only to Mental Health</p>

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Payment Term	Description	Amounts
	Services, only to Substance Abuse Services, or to a combination of both. Group [text] <sup>2</sup> Include if an Annual Deductible provision applies to Non-Network Benefits. [This [ <sup>1</sup> Mental Health Services] [and] [ <sup>1</sup> Substance Abuse Services] Out-of-Pocket Maximum does not include [ <sup>2</sup> the Annual Deductible or] the [ <sup>1</sup> Mental Health Services] [and] [ <sup>1</sup> Substance Abuse Services] Deductible.]	
	Group [text] Include if this OOPM provision does not apply to Non-Network Benefits. [This out-of-pocket maximum provision does not apply.]	

**[Durable Medical Equipment described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
Group [text] Must You Notify Us Column: <sup>1</sup> Include when group chooses a plan with an annual DME limit of more than \$1,000.	[ <u>Network</u> ] [No]	[[0 - 50]%] [No Copayment]	[Yes] [No]	[Not Applicable] [Yes][No]
Group [text] Must You Notify Us Column: <sup>2</sup> Include when group chooses a plan with an annual DME limit of \$1,000 or less per year.				

**[Durable Medical Equipment**

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a disease or disability.

[Non-Network]

[<sup>1</sup>Yes, for items more than \$1,000]  
[<sup>2</sup>No]

[0 - 50]%

[Yes] [No]

[Yes][No]

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
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If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment.

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. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also 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).

Group [text] <sup>1</sup>Include when group chooses a plan with DME purchase of every two-five years. The standard is once every three years.

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>Group [text] <sup>2</sup>Include when group chooses a plan with DME purchase of once every year.</p> <p>We provide Benefits only for a single purchase (including repair/ replacement) of a type of Durable Medical Equipment once every <sup>1</sup>two-five [calendar] [Policy] [<sup>1</sup>years][<sup>2</sup>year].</p> <p>We will decide if the equipment should be purchased or rented. To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify.</p>				
<p>Group [Para] Include when a group chooses to limit benefit.</p> <p>Group [text] <sup>1</sup>Insert benefit limit selected by group. Standard options are \$750, \$1,000, \$1,500, \$2,000 or \$2,500.</p> <p>Group [text] <sup>2</sup>Include if Annual Deductible provision applies.</p>				
<p>[Any combination of Network and Non-Network Benefits for Durable Medical Equipment is limited to [<sup>1</sup>\$750 - \$100,000] per [calendar] [Policy] year. This limit applies to the total amount that we will pay for the Durable Medical Equipment, and does not include any Copayment [<sup>2</sup>or Annual Deductible] responsibility you may have.]</p>				
<p>Group [Para] Include when group chooses a plan with an annual DME limit of more than \$1,000. When this option is selected, the Must You Notify Us? column should read "Yes for items more than \$1,000." If a group chooses a plan with an annual DME limit of \$1,000 or less per year, remove the entire notification requirement language and select "No" in the "Must You Notify Us?" column.</p>				
<b>[Notify Us</b>				
Please remember that for Non-Network Benefits you must notify us				

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
before obtaining any single item of Durable Medical Equipment that costs more than \$1,000 (either purchase price or cumulative rental of a single item). If you don't notify us, you will be responsible for paying all charges and no Benefits will be paid.]]				

**[Home Health Care described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Home Health Care]</b> Services received from a Home Health Agency that are both of the following:</p> <ul style="list-style-type: none"> <li>• Ordered by a Physician.</li> <li>• Provided by or supervised by a registered nurse in your home.</li> </ul>	<p><u>[Network]</u> [No]</p>	<p>[\$0 - 50] per visit [[0 - 50]%] [No Copayment] [<sup>2</sup>Your Copayment will range between \$[0 - 50] per visit]</p>	<p>[Yes][No]</p>	<p>[Not Applicable] [Yes][No]</p>
<p>Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required.</p> <p>Skilled care is skilled nursing, skilled teaching, and skilled</p>	<p><u>[Non-Network]</u> [Yes]</p>	<p>[0 - 50]%</p>	<p>[Yes][No]</p>	<p>[Yes][No]</p>

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
rehabilitation services when all of the following are true:				
<ul style="list-style-type: none"> <li>• 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.</li> <li>• It is ordered by a Physician.</li> <li>• 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.</li> <li>• It requires clinical training in order to be delivered safely and effectively.</li> <li>• It is not Custodial Care.</li> </ul>				
We will decide if skilled care is required 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.				
Group [Para]	Include when group chooses to limit benefit.			
Group [text]	<sup>1</sup> Insert benefit limit selected by group. Standard is 60 visits.			
[Any combination of Network and Non-Network Benefits is limited to [40 - 200] visits per [calendar][Policy] year. One visit equals four hours of skilled care services.]				
Group [text]	<sup>1</sup> When the benefit plan design is to reduce benefits by one-half, insert a number that is one-half of the non-network benefit level (i.e. if the out of network copayment is 20%, the benefit level is 80% and the number to			

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>insert here is 40%. Group [text] <sup>2</sup>When the benefit plan design is to reduce benefit to 50%, insert 50%.</p>	<b>Notify Us</b>			
<p>Please remember that for Non-Network Benefits you must notify us five business days before receiving services. If you don't notify us, Benefits will be reduced to [<sup>1-2</sup>25-50%] of Eligible Expenses.</p>				
<p>Group [text] <sup>2</sup>Include if Benefit design includes a variable Copayment for Network Benefits depending upon the Network provider selected.</p>	<p><b>[<sup>2</sup>For Network Benefits, the Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]]</b></p>			

*[Hospital - Inpatient Stay described in Section 1: (What's Covered - Benefits) is replaced with the following:]*

**[Benefit Information]**

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Hospital - Inpatient Stay]</b> Inpatient Stay in a Hospital. Benefits are available for:</p> <ul style="list-style-type: none"> <li>Supplies and non-Physician services received during the Inpatient Stay.</li> <li>Room and board in a Semi-private Room (a room with two or more beds).</li> </ul> <p>Admin. [text] <sup>1</sup>Include when facility-based Physicians are paid depending upon Network status and not as part of the facility charge.</p> <p>Benefits for Physician services <sup>1</sup>(including facility-based Physician services) are described under <i>Professional Fees for Surgical and Medical Services</i>.</p> <p style="text-align: center;"><b>Notify Us</b></p> <p>Please remember that for Non-Network Benefits you must notify us as follows:</p> <ul style="list-style-type: none"> <li>For elective admissions: five business days before admission.</li> <li>For non-elective admissions: within one business day or the same day of admission.</li> <li>For Emergency admissions: within one business day or the same</li> </ul>	<p><b>[<u>Network</u>]</b> [No]</p>	<p>[[0 - 50]%] [\$[0 - 25,000] per Inpatient Stay] [\$[0 - 1,000] per day] [\$[0 - 1,000] per day to a maximum of \$[0 - 5,000] per Inpatient Stay] [No Copayment] [<sup>3</sup>\$Your Copayment will range between \$[0 - 1,200] per day[, to a maximum of 4 days].]</p>	<p>[Yes] [No]</p>	<p>[Not Applicable] [Yes][No]</p>
<ul style="list-style-type: none"> <li>For elective admissions: five business days before admission.</li> <li>For non-elective admissions: within one business day or the same day of admission.</li> <li>For Emergency admissions: within one business day or the same</li> </ul>	<p><b>[<u>Non-Network</u>]</b> Yes]</p>	<p>[0 - 50]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
day of admission, or as soon as is reasonably possible.				
Group [text]	<sup>1</sup> When the benefit plan design is to reduce benefits by one-half, insert a number that is one-half of the non-network benefit level (i.e. if the out of network copayment is 20%, the benefit level is 80% and the number to insert here is 40%.)			
Group [text]	<sup>2</sup> When the benefit plan design is to reduce benefit to 50%, insert 50%.			
If you don't notify us, Benefits will be reduced to [ <sup>1-2</sup> 25-50%] of Eligible Expenses.				
Group [text]	<sup>3</sup> Include if Benefit design includes a variable Copayment for Network Benefits depending upon the Network provider selected.			
<b>[<sup>3</sup>For Network Benefits, the Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]]</b>				

**[Outpatient Surgery, Diagnostic and Therapeutic Services described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Outpatient Surgery, Diagnostic and Therapeutic Services]</b></p> <p><b><i>Outpatient Surgery</i></b> Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>Admin. [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge. Admin. [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.</p> <p>Benefits under this section include only the facility charge and the charge for <sup>1</sup>required Hospital-based professional services, supplies and equipment. Benefits for the surgeons fees <sup>2</sup>and facility-based Physician's fees related to outpatient surgery are described under <i>Professional Fees for Surgical and Medical Services</i>.</p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.</p> <p>Group [text] <sup>1</sup>Include if Benefit design includes a variable Copayment for Network</p>	<p><b>[Network]</b> [No]</p>	<p>[\$[0 - 1,000] per surgical procedure] [[0 - 50]% ] [No Copayment] <sup>1</sup>Your Copayment will range between \$[0 - 3,000] per surgical procedure]</p>	<p>[Yes] [No]</p>	<p>[Not Applicable] [Yes][No]</p>
	<p><b>[Non-Network]</b> [No]</p>	<p>[[0 - 50]%]</p>	<p>[Yes][No]</p>	<p>[Yes][No]</p>

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
Benefits depending upon the Network provider selected.				
<p><b>[<sup>1</sup> For Network Benefits, the Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]</b></p>				
<p><b>Outpatient Diagnostic Services</b> Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:</p>	<p><b>[Network]</b> [No]</p>	<p><b>For lab and radiology/Xray:</b> [\$[0 - 1,000] per test] [[0 - 50]% ] [No Copayment]</p>	<p>[Yes][No]</p>	<p>[Not Applicable] [Yes][No]</p>
<ul style="list-style-type: none"> <li>• Lab and radiology/X-ray.</li> <li>• Mammography testing.</li> </ul>		<p><b>For mammography testing:</b> [\$[0 - 1,000] per test] [[0 - 50]% ] [No Copayment]</p>	<p>[Yes][No]</p>	<p>[Not Applicable] [Yes][No]</p>
<p>Admin. [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge. Admin. [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.</p>				
<p>Benefits under this section include the facility charge, [<sup>1</sup>and] the charge for required services, supplies and equipment<sup>[1]</sup>, and all related professional fees]. [<sup>2</sup>Benefits for facility-based Physician's fees related to these services are described under <i>Professional Fees for Surgical and Medical Services.</i>]</p>	<p><b>[Non-Network]</b> [No]</p>	<p>[0 - 50]% [No]</p>		
<p>When these services are performed in a Physician's office, Benefits</p>				

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>are described under <i>Physician's Office Services</i> below.</p> <p>This section does not include Benefits for CT scans, Pet scans, MRIs, or nuclear medicine, which are described immediately below.</p>		Benefits for preventive care.]	[Yes][No]	[Yes][No]
<p><b><i>Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine</i></b></p> <p>Covered Health Services for CT scans, Pet scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.</p>	<p><b><u>[Network]</u></b> [No] [Yes]</p>	<p>[\$[0 - 1,000] per test [[0 - 50]% ] [No Copayment]] [<sup>1</sup>Your Copayment will range between \$[0 - 3,000] per test]</p>	[Yes][No]	<p>[Not Applicable] [Yes][No]</p>
<p>Admin. [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.</p> <p>Admin. [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.</p>				
<p>Benefits under this section include the facility charge, [<sup>1</sup>and] the charge for required services, supplies and equipment<sup>1</sup>, and all related professional fees]. [<sup>2</sup>Benefits for facility-based Physician's fees related to these services are described under <i>Professional Fees for Surgical and Medical Services.</i>]</p>	<p><b><u>[Non-Network]</u></b> [No] [Yes]</p>	[0 - 50]%]	[Yes][No]	[Yes][No]
<p>Group [Para] Include text and select yes under "Must you notify us" if notification is required. Option included for requiring notification by the Covered Person for Network Benefits - if this is required, remove the bracketed "for Non-Network Benefits" language.</p> <p>Group [text] <sup>1</sup>When the benefit plan design is to reduce benefits by one-half, insert a number that is one-half of the benefit level (i.e. if the copayment is 20%, the benefit level is 80% and the number to insert here is 40%).</p>				

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>Group [text] <sup>2</sup>When the benefit plan design is to reduce benefit to 50%, insert 50%.</p> <p style="text-align: center;"><b>[Notify Us]</b></p> <p>[Please remember that [for Non-Network Benefits] you must notify us before receiving these services. If you don't notify us, Benefits will be reduced to [<sup>1-2</sup>25-50%] of Eligible Expenses.]</p>				
<p>Group [text] <sup>1</sup>Include if Benefit design includes a variable Copayment for Network Benefits depending upon the Network provider selected.</p> <p><b>[<sup>1</sup> For Network Benefits, the Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]</b></p> <p><b><i>Outpatient Therapeutic Treatments</i></b></p> <p>Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.</p>	<p style="text-align: center;"><b>[Network]</b> [No]</p>	<p style="text-align: center;">[\$[0 - 1,000] per treatment] [[0 - 50]% ] [No Copayment]</p>	<p style="text-align: center;">[Yes][No]</p>	<p style="text-align: center;">[Not Applicable] [Yes][No]</p>
<p>Admin. [text] <sup>1</sup>Include (and delete #2 below) when facility-based Physician charges are paid as part of the facility charge.</p>				
<p>Admin. [text] <sup>2</sup>Include (and delete #1 above) when facility-based Physician charges are paid according to Network status.</p>				

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>Benefits under this section include the facility charge, <sup>[1]</sup>and the charge for required services, supplies and equipment<sup>[1]</sup>, and all related professional fees. <sup>[2]</sup>Benefits for facility-based Physician's fees related to these services are described under <i>Professional Fees for Surgical and Medical Services</i>.</p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.</p>	<p><u>[Non-Network]</u> [No]</p>	<p>[0 - 50]%</p>	<p>[Yes][No]</p>	<p>[Yes][No]</p>

**[Physicians Office Services described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Physician's Office Services]</b> Covered Health Services received in a Physician's office including:</p> <ul style="list-style-type: none"> <li>• Diagnosis and treatment of a Sickness or Injury.</li> <li>• Preventive medical care.</li> </ul>	<p><u>[Network]</u> [No]</p>	<p>[[5 - 75] per visit] [No Copayment applies when no Physician charge is assessed.]</p>	<p>[Yes][No]</p>	<p>[Not Applicable] [Yes. Prostate Cancer Screenings not subject to</p>

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<ul style="list-style-type: none"> <li>• Voluntary family planning.</li> <li>• Routine physical examinations.</li> <li>• Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See <i>Eye Examinations</i> earlier in this section.)</li> <li>• Well-baby and well-child care. Care shall include 20 visits at approximately the following age intervals: Birth, 2 Weeks, 2 Months, 4 Months, 6 Months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years and 18 years.</li> <li>• Immunizations. Please Note: No Copayment, Coinsurance or Deductible will be applicable to Children’s Immunization Services.</li> </ul>		<p style="text-align: center;">[[0 - 50%] [No Copayment [<sup>1</sup>Your Copayment will range between \$[0 – 75] per visit [[<sup>1</sup>\$[5 - 75] per visit], except that the Copayment for a Primary Physican office visit is \$[5 - 75] per visit [No Copayment applies when no Physician charge is assessed.]]</p>		<p style="text-align: center;">Annual Deductible. [No]</p>
<p><b>State Mandate</b></p>	<p style="text-align: center;"><b>[Non-Network]</b> [No]</p>	<p style="text-align: center;">[0 - 50]% [No Benefits for preventive care, except for children under the age of 19].</p>	<p style="text-align: center;">[Yes][No]</p>	<p style="text-align: center;">[Yes. Prostate Cancer Screenings not subject to Annual Deductible.] [No]</p>
<p>Group [text] <sup>1</sup>Include if Benefit design includes a variable Copayment for Network Benefits depending upon the Network provider selected.</p>	<p><i>[<sup>1</sup>For Network Benefits, the Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the</i></p>			

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<i>specific Copayment amount associated with each Network provider.]]</i>				

[Professional Fees for Surgical and Medical Services described in Section 1: (What's Covered - Benefits) is replaced with the following:]

**[Benefit Information]**

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Professional Fees for Surgical and Medical Services]</b> Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.</p>	<p><u>[Network]</u> [No]</p>	<p>[[0 - 50] %] [No Copayment]</p>	<p>[Yes] [No]</p>	<p>[Not Applicable] [Yes][No]</p>
<p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> above.]</p>	<p><u>[Non-Network]</u> [No]</p>	<p>[0 - 50] %</p>	<p>[Yes][No]</p>	<p>[Yes][No]</p>

**[Prosthetic Devices described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>[Prosthetic Devices]</b> External prosthetic devices that replace a limb or an external body part, limited to:</p>	<p><u>[Network]</u> [No]</p>	<p>[[0 - 50] %] [No Copayment]</p>	<p>[Yes] [No]</p>	<p>[Not Applicable] [Yes][No]</p>
<ul style="list-style-type: none"> <li>• Artificial arms, legs, feet and hands.</li> <li>• Artificial eyes, ears and noses.</li> <li>• 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.</li> </ul>	<p><u>[Non-Network]</u> [No]</p>	<p>[0 - 50] %</p>	<p>[Yes] [No]</p>	<p>[Yes][No]</p>
<p>If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.</p>				
<p>Group [text] <sup>1</sup>Include when group chooses a plan with a Prosthetic purchase every two or more years. The standard is once every three years. Group [text] <sup>2</sup>Include when group chooses a plan with a Prosthetic purchase of once every year.</p>				
<p>The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic</p>				

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
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device every [<sup>1</sup>two-five] [calendar] [Policy] [<sup>1</sup>years][<sup>2</sup>year].

Group [Para] Include when group chooses to limit benefit.  
 Group [text] <sup>1</sup>Insert benefit limit selected by group. Standard options are \$2,500 and \$5,000.  
 Group [text] <sup>2</sup>Include if Annual Deductible provision applies.

[Except for items required by the Women's Health and Cancer Rights Act of 1998, any combination of Network and Non-Network Benefits for prosthetic devices is limited to [<sup>1</sup>\$2,500-\$100,000] per [calendar] [Policy] year. This limit applies to the total amount that we will pay for the prosthetics, and does not include any Copayment [<sup>2</sup>or Annual Deductible] responsibility you may have.

Once this Benefit limit is reached, no additional Benefits are available except for items required by the Women's Health and Cancer Rights Act of 1998.]

**[Rehabilitation Services - Outpatient Therapy described in Section 1: (What's Covered - Benefits) is replaced with the following:]**

**[Benefit Information]**

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

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p><b>Therapy</b> Short-term outpatient rehabilitation services for:</p> <ul style="list-style-type: none"> <li>Physical therapy.</li> <li>Occupational therapy.</li> <li>Speech therapy.</li> <li>Pulmonary rehabilitation therapy.</li> <li>Cardiac rehabilitation therapy.</li> </ul>	[No]	[\$5 - 75] per visit [[0 - 50]%] [No Copayment] <sup>2</sup> Your Copayment will range between \$[0 - 75] per visit]	[Yes] [No]	[Not Applicable] [Yes][No]
Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.	<b><u>[Non-Network]</u></b> [No]	[0 - 50]%	[Yes] [No]	[Yes][No]

Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment.

Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.

**Group [Para]** Include when group chooses to limit benefit.  
**Group [text]** <sup>1</sup>Insert benefit limit selected by group. Standard is 20 visits for each, except that standard for cardiac therapy is 36 visits.

[Any combination of Network and Non-Network Benefits is limited as follows:

- [<sup>1</sup>10-100] visits of physical therapy per [calendar][Policy] year.

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[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<ul style="list-style-type: none"> <li>• [<sup>1</sup>10-100] visits of occupational therapy per [calendar][Policy] year.</li> <li>• [<sup>1</sup>10-100] visits of speech therapy per [calendar][Policy] year.</li> <li>• [<sup>1</sup>10-100] visits of pulmonary rehabilitation therapy per [calendar][Policy] year.</li> <li>• [<sup>1</sup>10-100] visits of cardiac rehabilitation therapy per [calendar][Policy] year.]</li> </ul>				
Group [text]	<sup>2</sup> Include if Benefit design includes a variable Copayment for Network Benefits depending upon the Network provider selected.			

**[<sup>2</sup>For Network Benefits, the Copayment that applies to this Benefit is based on which provider you select. Please refer to the directory of [Copayments] [providers], or call [Customer Service] [Member Services] at the telephone number on your ID card, or the website (www.xxxxx.com) to determine the specific Copayment amount associated with each Network provider.]]**

## [Section 2: What's Not Covered - Exclusions]

*[Section 2 is modified by replacing exclusion #3 under Medical Supplies and Appliances with the following exclusion:]*

### [Medical Supplies and Appliances]

- [3. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces).]

*[Section 2 is modified by replacing exclusion #3 under Mental Health/Substance Abuse with the following exclusion:]*

### [Mental Health/Substance Abuse]

- [3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.]

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

*[To continue reading, go to left column on next page.]*

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## [Section 3: Description of Network and Non-Network Benefits]

*[The introductory portion of the Network Benefits section in (Section 3: Description of Network and Non-Network Benefits) is replaced with the following:]*

### [Network Benefits]

[Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services which are:

- Provided by or under the immediate direction of your Primary Physician.
- Provided by or under the direction of a Network Physician or other Network provider when the Covered Health Service does not require a referral from your Primary Physician (as identified for you by your Primary Physician).
- 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.

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

- Emergency Health Services.

Admin. [text] <sup>1</sup>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).

<sup>1</sup>Covered Health Services provided in a Network facility by a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist) will be paid as Non-Network Benefits, unless the Covered Health Services are provided under the immediate direction of your Primary Physician.]]

*[Designated Facilities and Other Providers in (Section 3: Description of Network and Non-Network Benefits) is replaced with the following:]*

### [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 other provider chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a non-Network facility or provider.

[To continue reading, go to left column on next page.]

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 or other provider chosen by us.

You or your Primary Physician or other Network Physician must notify us of special service needs (including, but not limited to, transplants or cancer treatment) that might warrant referral to a Designated Facility or non-Network facility or provider. 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.]

***[The introductory portion of the Non-Network Benefits section in (Section 3: Description of Network and Non-Network Benefits) is replaced with the following:]***

### **[Non-Network Benefits]**

[Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services which are any of the following:

Admin. [text] <sup>1</sup>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).

- Provided by a non-Network Physician or other non-Network provider, not under the immediate direction of your Primary Physician.

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

- Provided at a non-Network facility, not under the immediate direction of your Primary Physician.
- <sup>1</sup>Provided by a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist) at a Network facility, unless the Covered Health Services are provided under the immediate direction of your Primary Physician.]

Admin. [text] <sup>1</sup>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 <sup>1</sup>through our [Shared Savings Program] to providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, and if your Copayment is expressed as a percentage of Eligible Expenses for Non-Network Benefits, that percentage 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 when you receive Covered Health Services <sup>1</sup>from [Shared Savings Program] providers than] from other non-Network providers, because the Eligible Expense may be a lesser amount.]

***[Emergency Health Services in (Section 3: Description of Network and Non-Network Benefits) is replaced with the following:]***

### **[Emergency Health Services]**

[We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

*[To continue reading, go to left column on next page.]*

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We provide Benefits for Emergency Health Services even if you do not have a referral from your Primary Physician. Whenever possible, you should contact your Primary Physician before receiving Emergency Health Services, and then seek care from the Network provider he or she designates. Network Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network provider.

If you are confined in a non-Network Hospital after you receive Emergency Health Services, we must be notified 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, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.]

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*[To continue reading, go to left column on next page.]*

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## [Section 5: How to File a Claim]

**[*Payment of Benefits in (Section 5: How to File a Claim) is replaced with the following:*]**

**[*Payment of Benefits*]**

Admin. [text] <sup>1</sup>Include the following provision and delete option #2 below if assignment of benefits is agreed to.

<sup>1</sup>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.]

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

<sup>2</sup>You may not assign your Benefits under the Policy to a non-Network provider without our consent. We may, however, in our discretion, pay a non-Network provider directly for services rendered to you.]

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[*To continue reading, go to left column on next page.*]

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## Section 9: General Legal Provisions

**[Subrogation and Reimbursement is replaced with the following:]**

### **[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 of Coverage, 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,

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

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.

*[To continue reading, go to left column on next page.]*

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- That we have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the event that you recover from a Third Party, we agree to pay our share of the reasonable costs of collection and attorney fees in the proportion we benefit from the recovery.
- 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.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors for 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.]

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## [Section 10: Glossary of Defined Terms]

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*[To continue reading, go to left column on next page.]*

**[The definition of Alternate Facility is replaced with the following:]**

**[Alternate Facility]** - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.]

Group [text] <sup>1</sup>Include text as standard for groups that purchase MH/SA coverage. Delete text if group has not purchased MH/SA benefits

<sup>1</sup>An Alternate Facility may also provide Mental Health Services or Substance Abuse Services on an outpatient or inpatient basis.]

**[The definition of Designated Facility is replaced with the following:]**

**[Designated Facility]** - a facility that has entered into an agreement on behalf of the facility and its affiliated staff 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.]

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

**[The definition of Eligible Expenses is replaced with the following:]**

**[Eligible Expenses]** - the amount we will pay for Covered Health Services, incurred while the Policy is in effect, are determined as stated below:

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

- When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated.

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

Admin. [text] Include the provisions that apply for determining Eligible Expenses for Non-Network Benefits.

- When Covered Health Services are received from non-Network providers, Eligible Expenses are determined, [at our discretion,] based on [ the lesser of]:
  - [[Available data resources of competitive fees in that geographic area.]
  - [Our most commonly used contracted fee(s) with Network providers for the same or similar service within the geographic market] [or] [the amount determined by us which Network providers have agreed to accept as payment in full.]

[To continue reading, go to left column on next page.]

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- [Fee(s) that are negotiated with the provider.]
- [A percentage of the published rates allowed by Medicare for the same or similar service [within the geographic market].]
- [A percentage of the published rates allowed by CMS for the same or similar service [within the geographic market].]
- [A percentage of the published rates allowed by Medicare in [name of county, name of state] for the same or similar service.]
- [A percentage of the published rates allowed by CMS in [name of county, name of state] for the same or similar service.]
- [\_\_% of the billed charge.]
- [A fee schedule that we develop.]
- When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider.

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.

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

- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.]

**[The definition of Network is replaced with the following:]**

Admin. [text] <sup>1</sup>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.

**[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 <sup>[1]</sup>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.]

[To continue reading, go to left column on next page.]

**[The definition of Network Benefits is replaced with the following:]**

**[Network Benefits]** - Benefits for Covered Health Services that are provided by or under the immediate direction of your Primary Physician. Network Benefits also include Covered Health Services that do not require a referral from your Primary Physician (as identified for you by your Primary Physician) that are provided by or under the direction of 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 Emergency Health Services.]

Admin. [text] <sup>1</sup>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).

**[The definition of Non-Network Benefits is replaced with the following:]**

**[Non-Network Benefits]** - Benefits for Covered Health Services that are provided by a non-Network Physician or other non-Network provider, not under the immediate direction of your Primary Physician, or Covered Health Services that are provided at a non-Network facility, not under the immediate direction of your Primary Physician. <sup>1</sup>Covered Health Services provided in a Network facility by a non-Network facility-based Physician (a non-Network anesthesiologist, radiologist, or pathologist) will be paid as Non-Network Benefits unless the Covered Health Services are provided under the immediate direction of your Primary Physician.]]

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**[The definition of Out-of-Pocket Maximum is replaced with the following:]**

Group [Para] Include if group chooses a plan design that includes an Out-of-Pocket-Maximum provision.  
Group [text] <sup>1</sup>Include if Annual Deductible provision applies and if the OOPM includes the Annual Deductible.

**[Out-of-Pocket Maximum]** - the maximum amount of <sup>1</sup>Annual Deductible and] Copayments you pay every [calendar] [Policy] year. If you use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once you reach the Out-of-Pocket Maximum for Network Benefits, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that [calendar] [Policy] year. Once you reach the Out-of-Pocket Maximum for Non-Network Benefits, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that [calendar] [Policy] year. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in (Section 1: What's Covered--Benefits) and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services.
- Copayments for Covered Health Services available by an optional Rider.
- The amount of any reduced Benefits if you don't notify us as described in (Section 1: What's Covered--Benefits) under the *Must You Notify Us?* column.
- Charges that exceed Eligible Expenses.

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- Any Copayments for Covered Health Services in Section 1: What's Covered--Benefits) that do not apply to the Out-of-Pocket Maximum.

Group [text] <sup>2</sup>include if an Annual Deductible provision applies, but is not included in the OOPM.

- [<sup>2</sup>The Annual Deductible.]

Even when the Out-of-Pocket Maximum has been reached, you will still be required to pay:

- Any charges for non-Covered Health Services.
- Charges that exceed Eligible Expenses.
- The amount of any reduced Benefits if you don't notify us as described in (Section 1: What's Covered - Benefits) under the *Must You Notify Us?* column.
- Copayments for Covered Health Services available by an optional Rider.
- Copayments for Covered Health Services in (Section 1: What's Covered - Benefits) that are subject to Copayments that do not apply to the Out-of-Pocket Maximum.]

**[The following definition of *Shared Savings Program* is added:]**

Admin. [text] <sup>1</sup>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.

[<sup>1</sup>***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, 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 Copayments calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.]

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

[To continue reading, go to left column on next page.]

SERFF Tracking Number: UHLC-126667084

State: Arkansas

Filing Company: UnitedHealthcare of Arkansas, Inc.

State Tracking Number: 45904

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: Prostate Cancer Screening

Project Name/Number: /

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Flesch Certification	Approved-Closed	06/17/2010
<b>Bypass Reason:</b>	N/A		
<b>Comments:</b>			
<b>Bypassed - Item:</b>	Application	Approved-Closed	06/17/2010
<b>Bypass Reason:</b>	N/A		
<b>Comments:</b>			
<b>Bypassed - Item:</b>	Health - Actuarial Justification	Approved-Closed	06/17/2010
<b>Bypass Reason:</b>	N/A		
<b>Comments:</b>			
<b>Bypassed - Item:</b>	Outline of Coverage	Approved-Closed	06/17/2010
<b>Bypass Reason:</b>	N/A		
<b>Comments:</b>			
<b>Bypassed - Item:</b>	PPACA Uniform Compliance Summary	Approved-Closed	06/17/2010
<b>Bypass Reason:</b>	N/A		
<b>Comments:</b>			

SERFF Tracking Number: UHLC-126667084 State: Arkansas  
Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 45904  
Company Tracking Number:  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: Prostate Cancer Screening  
Project Name/Number: /

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Cover Letter	Approved-Closed	06/17/2010
<b>Comments:</b>		
<b>Attachment:</b>		
AR 2001 COC series Prostate Cncr. Scrng. Cover Letter UHC of AR.pdf		

June 08, 2010,  
Via U.S. Mail

Rosalyn Minor  
Arkansas Insurance Department  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201

NAIC: 95446 United Healthcare of Arkansas, Inc.®

Form # [C][S]AMD.H.04.AR (Rev. 1/2010)  
[CP][SP]AMD.H.04.AR (Rev. 1/2010)  
CHCPLSAMD.H.02.AR (Rev. 1/2010)  
SELPLSAMD.H.02.AR (Rev. 1/2010)  
CHCAMD.H.02.AR (Rev. 1/2010)  
SELAMD.H.02.AR (Rev. 1/2010)

Dear Ms. Minor,

On behalf of United Healthcare of Arkansas, Inc., please accept this correspondence as a submission of the above referenced form filings for the Arkansas Insurance Department's ("the Department") review. The purpose of these forms is to bring our currently approved 2001 Certificate of Coverage forms into compliance with the Arkansas Mandate for Prostate Cancer Screening. The form numbers to those forms are as follows:

**AR2001HSelect**

**AR2001HSelectP**

**AR2001HChoice**

**AR2001HChoiceP.**

This submission has been submitted electronically via SERFF and United Healthcare of Arkansas, Inc. 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](mailto:Ebony_N_Terry@uhc.com).

Respectfully,

Ebony N. Terry  
Compliance Analyst  
Enclosure  
ENT

