

SERFF Tracking Number: UHLC-126680033 State: Arkansas
 Filing Company: UnitedHealthcare Insurance Company of the River Valley State Tracking Number: 45994
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: UnitedHealthcare of the River Valley
 Project Name/Number: /

Filing at a Glance

Company: UnitedHealthcare Insurance Company of the River Valley

Product Name: UnitedHealthcare of the River Valley SERFF Tr Num: UHLC-126680033 State: Arkansas

TOI: H21 Health - Other SERFF Status: Closed-Approved-Closed State Tr Num: 45994

Sub-TOI: H21.000 Health - Other Co Tr Num: State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor

Author: Ebony Terry Disposition Date: 07/08/2010

Date Submitted: 06/20/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 07/08/2010

Explanation for Other Group Market Type:

State Status Changed: 07/08/2010

Deemer Date:

Created By: Ebony Terry

Submitted By: Ebony Terry

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

Filing Description:

UHC River Valley Revised COC and Shedule of Benefit Forms

Company and Contact

Filing Contact Information

Ebony Terry, Compliance Analyst

Ebony_N_Terry@uhc.com

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800 King Farm Blvd. 240-632-8053 [Phone]
 Suite 500
 Rockville, MD 20850

Filing Company Information

UnitedHealthcare Insurance Company of the CoCode: 12231 State of Domicile: Illinois
 River Valley
 1300 River Drive, Suite 200 Group Code: 707 Company Type: Health
 Moline, IL 61265 Group Name: State ID Number:
 (309) 765-1485 ext. [Phone] FEIN Number: 20-1902768

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: 2 Forms x \$50.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company of the River Valley	\$100.00	06/20/2010	37334330

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/08/2010	07/08/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	06/29/2010	06/29/2010	Ebony Terry	06/30/2010	06/30/2010

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Disposition

Disposition Date: 07/08/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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

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TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: UnitedHealthcare of the River Valley
Project Name/Number: /

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 06/29/2010
Submitted Date 06/29/2010

Respond By Date

Dear Ebony Terry,

This will acknowledge receipt of the captioned filing.

Objection 1

- Schedule of Benefits, UHC AR Plus Schedule of Benefits 04/10 (Form)

Comment:

Before final review is given to this submission, please certify that benefits payable the In-Network and Out-of-Network provider will comply with our Bulletin 9-85 which states in part that there can be no more than a 25% differential in payment between the In-Network (PPO) and Out-of-Network (Non-PPO) provider.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Product Name: UnitedHealthcare of the River Valley
Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
Response Letter Date 06/30/2010
Submitted Date 06/30/2010

Dear Rosalind Minor,

Comments:

Response 1

Comments: We certify that benefits payable for the In-Network and Out-of Network provider will comply with AR Bulletin 9-85 which states in part that there can be no more than a 25% differential in payment between the In-Network (PPO) and Out-of-Network (Non-PPO) provider.

Related Objection 1

Applies To:

- Schedule of Benefits, UHC AR Plus Schedule of Benefits 04/10 (Form)

Comment:

Before final review is given to this submission, please certify that benefits payable the In-Network and Out-of-Network provider will comply with our Bulletin 9-85 which states in part that there can be no more than a 25% differential in payment between the In-Network (PPO) and Out-of-Network (Non-PPO) provider.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Should you have any additional questions, comments or concerns, please feel free to contact me at 240.632.8056, Ebony_N_Terry@uhc.com or through the SERFF messaging system.

Sincerely,

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/08/2010	UHC AR Plus COC 04-10	Certificate	Certificate of Coverage	Revised	Replaced Form #: UHC AR Plus COC 04-10 Previous Filing #: UHC AR Plus COC 04-10		AR COC Revised 6.16.10.pdf
Approved-Closed 07/08/2010	UHC AR Plus Schedule of Benefits 04/10	Schedule Pages	Schedule of Benefits	Revised	Replaced Form #: UHC AR Plus Schedule of Benefits 04/10 Previous Filing #: UHC AR Plus Schedule of Benefits 04/10		AR Att D Sch of Bene final Revised 6.16.10.pdf

**THIS CONTRACT
PROVIDES FOR COMPREHENSIVE
HEALTH CARE TO THE EXTENT HEREIN
LIMITED AND DEFINED**

Issued By

UnitedHealthcare Insurance Company of the River Valley

**A Corporation Certified Under the Applicable Laws
of the State of Operation**

**CERTIFICATE OF COVERAGE
UNDER GROUP HEALTH CONTRACT**

This Contract between the Subscriber who has enrolled and UnitedHealthcare Insurance Company of the River Valley ("UnitedHealthcare") is part of the Group Health Contract between UnitedHealthcare and Group through which the Member has enrolled. The Group Health Contract and this Contract, as defined in Article 1, form the entire contract.

This Contract entitles the Subscriber and Eligible Dependents to receive the benefits set forth herein during the Contract Period, subject to the terms and conditions of this Contract and upon payment of the Premium.

**UnitedHealthcare Insurance Company of the River Valley
1300 River Drive, Suite 200
Moline, Illinois 61265**



**By: _____
President**

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ARTICLE 1 – DEFINITIONS

Use this section if using MNRP

- [1.1] **Allowed Charge** – the portion of a charge for a Covered Service that UnitedHealthcare will consider in calculating benefits. The Allowed Charge is determined as follows:
- 1.1.1 **Participating Provider:** For Covered Services received from a Participating Provider, the Allowed Charge is the rate UnitedHealthcare has agreed to pay the Participating Provider under a contract.
 - 1.1.2 **Non – Participating Provider – Medical Emergency:** For Covered Services received from a Non-Participating Provider due to an Emergency Medical Condition, the Allowed Charge is the “In-Network” level of benefits, shown in Attachment D. If the Billed Charge exceeds the “In-Network” level of benefits, the Member is not responsible for paying the Non-Participating Provider the difference between the Non-Participating Provider’s Billed Charge and the “In-Network” level of benefits.
 - 1.1.3 **Non-Participating Provider – Non-Emergency.** For non-emergency Covered Services received from a Non-Participating Provider, the Allowed Charge is determined based on the following maximum non-network reimbursement program (MNRP) rate in the order set forth below:
 - 1.1.3.1 Fee(s) that are negotiated with the Provider who has agreed to discount their charges.
 - 1.1.3.2 If rates have not been negotiated, then one of the following amounts
 - 1.1.3.2.1 [110][140] percent of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, if the Covered Services are not provided by a Non-Participating Provider who has negotiated a discount in fees with UnitedHealthcare.
 - 1.1.3.3 When a rate is not published by CMS for the service, an available gap methodology to determine a rate for the service would be used as follows:
 - 1.1.3.3.1 For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by Ingenix. If the Ingenix relative value scale becomes no longer available, a comparable scale will be used. UnitedHealthcare and Ingenix are related companies through common ownership by UnitedHealth Group.
 - 1.1.3.3.2 For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
 - 1.1.3.4 When a rate is not published by CMS for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under CMS published rates or a gap methodology, the Allowed Charge is based on 50 percent of the provider’s billed charge, except that certain Covered Services for mental health and substance abuse services are based on 80 percent of the billed charge.

If the Billed Charge exceeds the MNRP rate, the Member is responsible for paying the Non-Participating Provider the difference between the Non-Participating Provider's Billed Charge and the MNRP rate.]

Use this section for maximum allowance

- [1.1 **Allowed Charge** – the portion of a charge for a Covered Service that UnitedHealthcare will consider in calculating benefits. The Allowed Charge is determined as follows:
 - 1.1.1 **Participating Provider.** For Covered Services received from a Participating Provider, the Allowed Charge is the rate UnitedHealthcare has agreed to pay the Participating Provider under a contract.
 - 1.1.2 **Non-Participating Provider – Medical Emergency.** For Covered Services received from a Non-Participating Provider due to a Medical Emergency, the Allowed Charge is the Maximum Allowance. If the Billed Charge exceeds the Maximum Allowance, the Member is not responsible for paying the Non-Participating Provider the difference between the Non-Participating Provider's Billed Charge and the Maximum Allowance.
 - 1.1.3 **Non-Participating Provider – Non-Emergency.** For non-emergency Covered Services received from a Non-Participating Provider, the Allowed Charge is the Maximum Allowance. If the Billed Charge exceeds the Maximum Allowance, the Member is responsible for paying the Non-Participating Provider the difference between the Non-Participating Provider's Billed Charge and the Maximum Allowance.]
- 1.2 **Appeal** – a complaint which, having been reported by the Member and remaining unresolved to the Member's satisfaction, is filed for formal proceedings as set forth in Article 17.
- 1.3 **Attending Physician** – a Physician who is primarily responsible for the care of Members with respect to any particular injury or illness.
- 1.4 **Billed Charge** – the amount a Provider bills for any services and supplies, whether or not the services or supplies are covered under this Contract. The Billed Charge may be different from the amount that UnitedHealthcare determines to be the Allowed Charge.
- 1.5 **Coinsurance** – a percentage of the Allowed Charge that the Member must pay for Covered Services received. The percentage is shown in Attachment D.
- 1.6 **Contract** – this Certificate of Coverage, any endorsements hereon and attached papers, if any, and the Subscriber's application constitute the entire Contract between UnitedHealthcare and the Subscriber.
- 1.7 **Contract Period** – refer to Attachment A.
- 1.8 **Copayment** – the amount, if any, the Member must pay for each Covered Service received, such as a doctor visit. The amount is specified per service and is shown in Attachment D. Each Copayment shall be paid at the time the service is provided.
- 1.9 **Covered Service(s)** – a service, procedure, treatment, supply, device, or item specified in this Contract for which benefits will be provided when medically necessary.
- [1.10 **Deductible** – the dollar amount, if any, the Member must pay for health services before benefits are payable under this Contract. The amount is shown in Attachment D. Only those charges which would otherwise be payable by UnitedHealthcare in the absence of application of the Deductible shall count toward the Deductible.
 - 1.10.1 The following amounts will not count toward any applicable Deductible:

[1.10.1.1 Copayments.]

1.10.1.2 Amounts in excess of the [MNRP rate][Maximum Allowance], whether or not paid by the Member.

1.10.1.3 Amounts paid by the Member in connection with supplemental benefits, if any supplemental benefits rider is attached to this Contract, such as but not limited to prescription drug, dental, vision, chiropractic, or hearing.

1.10.1.4 Penalty amounts paid by the Member for failing to comply with Preauthorization requirements set forth in section 6.1.1 and Attachment D.]

[1.10.2 **4th Quarter Deductible Carryover:** Dollar amounts incurred by a Member during the last three months of a [calendar year][Contract Period], which were counted toward any applicable Deductible during that [calendar year][Contract Period] of a UnitedHealthcare benefit plan with a 4th Quarter Deductible Carryover provision, will also count toward any applicable Deductible for the following [calendar year][Contract Period].]

[1.10 **Deductible** – the amount the Member must pay for health services before UnitedHealthcare begins to pay, as shown for self-only or family coverage in Attachment D. Only those charges which would otherwise be payable by UnitedHealthcare in the absence of application of the Deductible shall count toward the Deductible.

1.10.1 The Deductible amount for self-only coverage applies when the Subscriber alone is covered by this Contract; the Deductible amount for family coverage applies when the Subscriber and Eligible Dependents are covered by this Contract.

1.10.2 If the Subscriber with self-only coverage later enrolls Eligible Dependents under this Contract, any applicable Deductible amount shown for family coverage in Attachment D will then apply. Any Deductible amount accumulated under self-only coverage will then be counted toward any applicable Deductible amount shown for family coverage in Attachment D.

1.10.3 If any supplemental benefits rider other than dental or vision is attached to this Contract, amounts paid by the Member in connection with such supplemental benefits rider will count toward any applicable Deductible shown in Attachment D,

1.10.4 The following amounts will not count toward any applicable Deductible:

1.10.4.1 amounts or charges in excess of the [MNRP rate][Maximum Allowance], whether or not paid by Member.

[1.10.4.2 Penalty amounts paid by the Member for failing to comply with Preauthorization requirements set forth in section 6.1.1 and Attachment D.]

[1.10.6 **4th Quarter Deductible Carryover:** Dollar amounts incurred by a Member during the last three months of a [calendar year][Contract Period], which were counted toward any applicable Deductible during that [calendar year][Contract Period] of a UnitedHealthcare benefit plan with a 4th Quarter Deductible Carryover provision, will also count toward any applicable Deductible for the following [calendar year][Contract Period].]

[1.11 **Domestic Partner** – a person of the [same][opposite] [same or opposite] sex with whom the Subscriber has established a Domestic Partnership.]

[1.12 **Domestic Partnership** – a relationship between the Subscriber and one other person of the

[same][opposite] [same or opposite] sex such that both persons can represent and warrant that the statements as provided on the Affidavit of Domestic Partnership are true and correct.]

- [1.13] **Eligible Dependent** – a person who meets UnitedHealthcare's eligibility requirements set forth in Attachment B.
 - [1.14] **Group** – the sole proprietor, partnership, association or corporation, including any and all successors, through which the Member has enrolled, and which has agreed to collect and remit the Premiums payable under this Contract.
 - [1.15] **Home Health Services** – skilled nursing care, when a Member is confined to his or her home related to a recuperative or treatable illness or injury and when provided by a Home Health Agency.
 - [1.16] **Home Health Agency** – a public or private agency that specializes in providing skilled nursing services in the home, and is duly licensed to operate as a Home Health Agency under applicable state or local laws.
 - [1.17] **Hospital** – an acute care general Hospital providing Hospital Services to Members.
 - [1.18] **Hospital Services** – bed and board of the character classed as semiprivate or intensive care and all other services customarily furnished in a Hospital or Skilled Nursing Facility.
 - [1.19] **Inherited Metabolic Disease** – a disease caused by an inherited abnormality of body chemistry.
 - [1.20] **Low Protein Modified Food Product** - a food product specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an Inherited Metabolic Disease under the direction of a Physician.
- Remove this section if MNRP is used.*
- [1.21] **Maximum Allowance** – the portion of a Non-Participating Provider's charge which UnitedHealthcare will consider in calculating benefits. The Maximum Allowance will be determined based on UnitedHealthcare's determination of the average discount UnitedHealthcare has negotiated with Participating Providers for that service. If the Billed Charge exceeds the Maximum Allowance, the Member is responsible for paying the Non-Participating Provider the difference between the Non-Participating Provider's Billed Charge and the Maximum Allowance, except when services were rendered in a Medical Emergency. Any amount paid by a Member which is in excess of the Maximum Allowance for Covered Services shall not count toward any applicable Deductible or Maximum Out-of-Pocket Expense.]
 - [[1.22] **Maximum Out-of-Pocket Expense** – the sum total amount of [Copayments, Coinsurance, and Deductibles] [Coinsurance and Deductibles], as shown for an individual or family in Attachment D and paid by a Member, after which – for the remainder of the [calendar year] [Contract Period] – UnitedHealthcare will pay 100% of the Allowed Charge for that Member's subsequent Covered Services under this Contract.

1.22.1 The following amounts will not count toward any applicable Maximum Out-of-Pocket Expense, and the Member's responsibility for paying these amounts will continue even after the Member has met any applicable Maximum Out-of-Pocket Expense:

[1.22.1.1 Copayments.]

1.22.1.2 amounts in excess of the [MNRP rate][Maximum Allowance].

1.22.1.3 amounts payable by the Member in connection with supplemental benefits, if any supplemental benefits rider is attached to this Contract, such as but not limited to prescription drug, dental, vision, or hearing.

[1.22.1.4] Penalty amounts payable by the Member for failing to comply with Preauthorization requirements set forth in section 6.1.1 and Attachment D.]]

[[1.22] **Maximum Out-of-Pocket Expense** – the sum total amount of applicable Copayments, Coinsurance, and Deductibles, as shown for self-only or family coverage in Attachment D and paid by a Member, after which – for the remainder of the [calendar year] [Contract Period] – UnitedHealthcare will pay 100% of the Allowed Charge for that Member’s subsequent Covered Services under this Contract.

1.22.1 The total for self-only coverage applies when the Subscriber alone is covered by this Contract; the total for family coverage applies when the Subscriber and Eligible Dependents are covered by this Contract.

1.22.2 If the Subscriber with self-only coverage later enrolls Eligible Dependents under this Contract, the applicable Maximum Out-of-Pocket Expense amount shown for family coverage in Attachment D will then apply. Any Maximum Out-of-Pocket Expense amount accumulated under self-only coverage will then be counted toward the Maximum Out-of-Pocket Expense amount shown for family coverage in Attachment D.

1.22.3 If any supplemental benefits rider other than dental or vision is attached to this Contract, amounts paid by the Member in connection with such supplemental benefits rider will count toward any applicable Maximum Out-of-Pocket Expense shown in Attachment D.

1.22.4 The following amounts will not count toward any applicable Maximum Out-of-Pocket Expense, and the Member’s responsibility for paying these amounts will continue even after the Member has met any applicable Maximum Out-of-Pocket Expense:

1.22.4.1 amounts or charges in excess of the [MNRP rate][Maximum Allowance], whether or not paid by the Member.

[1.22.4.2] Penalty amounts payable by the Member for failing to comply with Preauthorization requirements set forth in section 6.1.1 and Attachment D.]]

[1.23] **Maximum Policy Benefit** - for benefit plans that have a Maximum Policy Benefit, this is the maximum amount that UnitedHealthcare will pay for benefits during the entire period of time that Members are enrolled under the Contract. Refer to the Attachment D to determine whether or not the benefit plan is subject to a Maximum Policy Benefit and for details about how the Maximum Policy Benefit applies.

[1.24] **Medical Emergency** - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1.24.1 placing the health of the individual (or, with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy; or

1.24.2 serious impairment of bodily functions; or

1.24.3 serious dysfunction of any bodily organ or part.

[1.25] **Medical Foods** - food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician.

[1.26] **Medicare** – Title XVIII of the Social Security Act, as amended from time to time.

[1.27] **Member** – the Subscriber and any Eligible Dependents who are enrolled in UnitedHealthcare.

- [1.28] **Non-Participating Physician** – a Physician who has not entered into a Participating Physician's agreement, either with UnitedHealthcare, an entity affiliated with UnitedHealthcare, or another entity which has a contractual relationship with UnitedHealthcare, for the provision of health care services to Members.
- Always include unless the Shared Savings Program does not apply. "Shared Savings Program" is bracketed to accommodate possible name change.*
- [1.29] **Non-Participating Provider** – any Provider licensed to provide medical services, including but not limited to a Physician, Hospital, or extended care facility, that does not have a contractual relationship with UnitedHealthcare, or another entity which has a contractual relationship with UnitedHealthcare, for the provision of health care services to Members. [However, this does not include those providers who have agreed to discount their charges for Covered Services 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.]
- [1.30] **Orthotic Device** - an external device that is, (i) intended to restore physiological function or cosmesis to a Member; and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the Member using the device prior to concurrent with the delivery of the device to the Member.
- [1.31] **Orthotic Service** - the evaluation and treatment of a condition that requires the use of an Orthotic Device.
- [1.32] **Participating Hospital** - an acute care general Hospital which has entered into a contractual relationship with UnitedHealthcare, or another entity which has a contractual relationship with UnitedHealthcare, for the provision of Hospital Services to Members.
- [1.33] **Participating Physician** – a Physician who has entered into a Participating Physician's agreement, either with UnitedHealthcare or with another entity which has a contractual relationship with UnitedHealthcare, or another entity which has a contractual relationship with UnitedHealthcare, for the provision of health care services to Members.
- [1.34] **Participating Provider** – any Provider, including but not limited to a Physician, Hospital, or extended care facility, that has entered into a contractual relationship with UnitedHealthcare, or another entity which has a contractual relationship with UnitedHealthcare, for the provision of health care services to Members.
- [[1.35] **Penalty** – additional Member payment required as a result of Member's failure to comply with Preauthorization requirements for certain Covered Services from Non-Participating Providers as described in section 6.1.1. The amount is shown in Attachment D. Any Penalty amount paid by the Member will not count toward any applicable Deductible or Maximum Out-of-Pocket Expense.]
- [1.36] **Pharmaceutical Product(s)** - FDA-approved prescription pharmaceutical products administered in connection with a Covered Service by a Physician or other health care Provider within the scope of the Provider's license, and not otherwise excluded under this Contract.
- [1.37] **Physician** – a person who is properly licensed and qualified by law to practice medicine in any of its branches.
- [[1.38] **Preauthorization** – as described in section 6.1.1, prior to the time certain services, items, and procedures are furnished, approval from UnitedHealthcare [(or, for mental health and substance abuse services, from UnitedHealthcare's mental health and/or substance abuse treatment program provider)] for those services, items, and procedures to be covered. UnitedHealthcare establishes the criteria used to determine the appropriateness of the services, items, and procedures and the level of care that will be covered. If a Member has any question as to whether or not a service, item, or procedure requires Preauthorization, he or she should contact UnitedHealthcare at the toll-free telephone number listed in Attachment C, or visit the UnitedHealthcare web site also listed in Attachment C.]
- [[1.39] **Primary Care Physician (PCP)** – any Participating Physician who is designated by UnitedHealthcare as a Primary Care Physician.]

- [1.40] **Prosthetic Device** - an external device that is (i) intended to replace an external body part for the purpose of restoring physiological function or cosmesis to a patient; and (ii) custom designed, fabricated, assembled, fitted, or adjusted for patient using the device prior to or concurrent with being delivered to the Member.
- [1.41] **Prosthetic Service** - the evaluation and treatment of a condition that requires the use of a Prosthetic Device.
- [1.42] **Provider** – any Provider licensed to provide medical services, including but not limited to a Physician, Hospital, or extended care facility.
- [1.43] **Premium** – the periodic amount of money currently charged by UnitedHealthcare for benefits and services provided under this Contract.
- ¹*Always include unless the Shared Savings Program does not apply. “Shared Savings Program” is bracketed to accommodate possible name change.*
- [[1.44] **Shared Savings Program** - the Shared Savings Program provides access to discounts from the provider's charges when services are rendered by those Non-Participating Providers that participate in that program. We will use the Shared Savings Program to pay claims when doing so will lower Allowed Charges. We do not credential the Shared Savings Program providers and the Shared Savings Program providers are not Participating Providers. Accordingly, in benefit plans that have both Participating and Non-Participating levels of benefits, benefits for Covered Services provided by Shared Savings Program providers will be paid at the Non-Participating Provider benefit level (except in situations when benefits for Covered Services provided by Non-Participating Providers are payable at Participating Provider benefit levels, as in the case of Medical Emergency services). When we use the Shared Saving Program to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required annual Deductible.]
- [1.45] **Skilled Nursing Facility** – an extended care facility which is accredited as a Skilled Nursing Facility under applicable state law or is recognized and eligible for payment under Medicare.
- [[1.46] **Specialist** – any Participating Physician who is not designated by UnitedHealthcare as a Primary Care Physician.]
- [1.47] **Subscriber** – an individual who is eligible to participate in the health benefit plan offered by Group under this Contract and who has enrolled under this Contract.
- [1.48] **Urgent Care Facility** - a facility that provides Covered Services that are required to prevent serious deterioration of the Member’s health, and that are required as a result of an unforeseen sickness, injury, or the onset of acute or severe symptoms.

ARTICLE 2 - ELIGIBILITY DATE/EFFECTIVE DATE

- 2.1 The eligibility date shall be the date on which a Member is first deemed eligible by UnitedHealthcare to participate under this Contract.
- 2.2 Eligibility of Subscribers and Eligible Dependents shall be determined as set forth in Attachment B.
- 2.3 The coverage effective date shall be the date on which a Member is first deemed eligible by UnitedHealthcare to receive benefits under this Contract.
- 2.4 Benefits shall be provided when the Member receives services on or after the coverage effective date, except as set forth in section 2.6.
- 2.5 Coverage for a new Eligible Dependent acquired by reason of birth, legal adoption, placement for adoption, court or administrative order, or marriage will take effect on the date of the event. Coverage is effective

only if we receive any required Premium and are notified within 90 days of the birth, 60 days of the adoption or placement for adoption, or 31 days of the court or administrative order or marriage.

2.6 **Changes in Eligibility Status.** Subscriber shall provide Group written notification of any dependent status change within 31 days of such change.

2.6.1 The Subscriber's failure to notify Group of a Member's loss of Eligible Dependent status (for example, due to change in student status) shall not extend any person's coverage beyond the last day on which he or she qualifies as an Eligible Dependent.

2.6.2 *Canceling Coverage for Eligible Dependents:* When the Subscriber discontinues coverage for one or more Eligible Dependents, if notification of such change is received more than [31, 60, or 90] days after the desired date of coverage change, the implemented date of the change will not be more than [31, 60, or 90] days prior to the date Group received proper notification to remove the Eligible Dependent(s) from coverage.

2.6.3 *Adding Eligible Dependents:* See *Special Enrollment*, section 2.7 of this Article.

2.7 **Special Enrollment.** UnitedHealthcare shall provide a Special Enrollment Period during which an eligible individual may enroll for coverage under this Contract under certain conditions. For purposes of this section, the term "Special Enrollment Period" means a period during which an eligible employee is allowed to request coverage for himself/herself and/or any Eligible Dependents upon the occurrence of certain events and conditions as described below in sections 2.7.1, 2.7.2, and 2.7.3.

2.7.1 *Prior coverage terminated or exhausted.* A Special Enrollment Period is available due to loss of group or other health insurance coverage as described in this section.

2.7.1.1 *Coverage loss which creates special enrollment opportunity.* Special enrollment is available to persons specified in section 2.7.1.2 when:

2.7.1.1.1 COBRA continuation coverage with a prior carrier is exhausted; or

2.7.1.1.2 Coverage under another group health plan or other health insurance coverage, which is not under COBRA continuation coverage, has terminated as a result of (a) loss of eligibility for reasons such as legal separation, divorce, death, termination of employment or reduction in the number of hours worked, (b) cessation of employer contributions, (c) the plan no longer offers benefits to a class of individuals that include the eligible employee and/or Eligible Dependent, (d) the eligible employee and/or Eligible Dependent incurs a claim that would exceed a lifetime limit on all benefits, or (e) the eligible employee and/or Eligible Dependent loses eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

2.7.1.2 *Persons who may be entitled to special enrollment due to loss of prior coverage.* A Special Enrollment Period will be allowed for the persons described below when a loss of coverage described in section 2.7.1.1 has occurred, and if enrollment takes place during the Special Enrollment Period:

2.7.1.2.1 *For an eligible employee,* upon losing coverage under another plan.

2.7.1.2.2 *For an Eligible Dependent,* upon losing coverage under another plan, but only if such individual is an Eligible Dependent of an employee who is already covered under this Contract.

2.7.1.2.3 *For both the eligible employee and the employee's Eligible Dependent,* if

either loses coverage under another plan.

2.7.1.3 In order to enroll due to loss of coverage as described above, the following conditions must be met:

2.7.1.3.1 The individual must be eligible to enroll under this Contract; and

2.7.1.3.2 The individual declined coverage under this Contract when the person first became eligible; and

2.7.1.3.3 When the individual declined such coverage, the individual was covered under another group's health plan or other health coverage; and

2.7.1.3.4 The employee stated in writing to UnitedHealthcare (if UnitedHealthcare required such a statement) that the existence of other coverage was the reason for declining enrollment for the employee and/or Eligible Dependents.

2.7.1.4 *Special Enrollment Period for Section 2.7.1.* To enroll due to loss of coverage, the employee must apply for coverage for the employee and/or Eligible Dependent within 90 days of the birth, 60 days of the adoption or placement for adoption or 31 days of the court or administrative order or marriage, except that in order to enroll due to loss of eligibility for Medicaid or CHIP the employee must apply for coverage for the employee and/or Eligible Dependent within 60 days of loss of Medicaid or CHIP coverage.

2.7.2 *Acquisition of a Dependent.* A Special Enrollment Period will be allowed for the persons described below when the described events occur, and if they request coverage during the Special Enrollment Period stated in section 2.7.2.6.

2.7.2.1 *For an employee who is eligible but not enrolled:* when he/she marries or has a new child as the result of marriage, birth, adoption, interim court order for adoption or legal guardianship, or placement for adoption;

2.7.2.2 *For an individual who becomes a spouse of a Subscriber:* at the time of marriage, or when a child becomes an Eligible Dependent of that Subscriber as the result of birth, adoption, interim court order for adoption or legal guardianship, or placement for adoption;

2.7.2.3 *For both an employee who is eligible but not enrolled and an eligible spouse:* when they marry or when a child becomes an Eligible Dependent of the employee as a result of birth, adoption, interim court order for adoption or legal guardianship, or placement for adoption;

2.7.2.4 *For a child:* upon becoming an Eligible Dependent of a Subscriber as the result of marriage, birth, adoption, interim court order for adoption or legal guardianship, or placement for adoption;

2.7.2.5 *For both an employee who is eligible but not enrolled and a child:* when the child becomes an Eligible Dependent of the employee as the result of marriage, birth, adoption, interim court order for adoption or legal guardianship, or placement for adoption;

2.7.2.6 *Special enrollment period for section 2.7.2.* The employee must request coverage for the employee and/or Eligible Dependent/s within 90 days of the birth, 60 days of the adoption or placement for adoption or 31 days of the court or administrative order or marriage.

- 2.7.3 *Eligibility for State Premium Assistance Subsidy.* A Special Enrollment Period will be allowed for both an eligible employee and/or the employee’s Eligible Dependent if the eligible employee and/or Eligible Dependent become eligible for a state premium assistance subsidy for employer group health coverage. To enroll pursuant to this Section 2.7.3, the employee must apply for coverage for the employee and/or Eligible Dependent within sixty (60) days of the date of eligibility for the subsidy.
- 2.7.4 *Effective date of Enrollment.* For those enrolled during a Special Enrollment Period, enrollment is effective as follows:
- 2.7.4.1 *Loss of Coverage.* In the case of prior coverage being terminated or exhausted, not later than the first day of the first calendar month beginning after the date the request for enrollment is received.
- 2.7.4.2 *Marriage.* In the case of marriage, not later than the first day of the first calendar month beginning after the date the request for enrollment is received.
- 2.7.4.3 *Birth.* In the case of an Eligible Dependent’s birth, on the date of such birth.
- 2.7.4.4 *Adoption, Interim Court Order for Adoption or Legal Guardianship, or Placement for Adoption.* In the case of an Eligible Dependent’s adoption, interim court order for adoption or legal guardianship, or placement for adoption, on the date of such adoption, interim court order for adoption or legal guardianship, or placement for adoption.
- 2.7.4.5 *Eligibility for State Premium Assistance Subsidy.* In the case of the eligible employee and/or Eligible Dependent becoming eligible for a state premium assistance subsidy for employer group health coverage, not later than the first day of the first calendar month beginning after the date the request for enrollment is received.
- 2.7.5 For purposes of counting creditable coverage, the enrollment date for anyone who enrolls under a Special Enrollment Period is the first day of coverage. That is, the time between the date an individual becomes eligible for enrollment under this Contract and the first day of coverage is not treated as a waiting period.

ARTICLE 3 – PARTICIPATING AND NON-PARTICIPATING PROVIDERS

- 3.1 **Participating Providers.** When a Member uses Participating Providers, the Participating Providers are responsible for making arrangements with UnitedHealthcare for coverage of a Member’s care, including but not limited to complying with the medical management requirements set forth in Article 6, and for submitting claims. [Covered Services from Participating Providers will be paid at the “In-Network” level of benefits shown in Attachment D.]
- 3.2 **Non-Participating Providers.** When a Member uses Non-Participating Providers, the Member is responsible for making arrangements with UnitedHealthcare for coverage of his or her care, including but not limited to complying with the medical management requirements set forth in Article 6, and for submitting claims for reimbursement in accordance with Article 11.
- 3.2.1 **Non-Participating Providers – Medical Emergency.** Covered Services from Non-Participating Providers in a Medical Emergency will be paid at the “In-Network” level of benefits shown in Attachment D, and the Member is not responsible for paying any amounts or charges exceeding the [Maximum Allowance] [“In-Network” level of benefits].

- 3.2.2 **Non-Participating Providers – Non-Emergency.** Non-emergency Covered Services from Non-Participating Providers will be paid at the “Out-of-Network” level of benefits shown in Attachment D, and the Member is responsible for paying any amounts or charges exceeding the [MNRP rate][Maximum Allowance].
- 3.3 **WARNING: LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED.** Members should be aware that when they elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. **MEMBERS CAN EXPECT TO PAY MORE THAN THE DEDUCTIBLE AND COINSURANCE AMOUNTS DEFINED IN THIS CONTRACT AFTER UNITEDHEALTHCARE HAS PAID ITS REQUIRED PORTION.** Non-Participating Providers may bill members for any amount up to the Billed Charge after UnitedHealthcare has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the Member other than Copayments, Coinsurance, and Deductible amounts. Members may obtain further information about the participating status of professional Providers and information on Maximum Out-of-Pocket Expenses by calling UnitedHealthcare at the toll-free telephone number on the back of their identification card.
- 3.4 Charges for any service not payable to a Participating Provider will not be payable to a Non-Participating Provider.
- 3.5 Participating Providers are listed in the UnitedHealthcare provider directory. A Provider’s status may change. Before obtaining services, a Member should verify the network participation status of a Provider. If a Member has any question as to whether or not a Provider is a Participating Provider, he or she should call UnitedHealthcare at the toll-free telephone number listed in Attachment C, or visit the UnitedHealthcare web site also listed in Attachment C.

ARTICLE 4 – GENERAL PROVISIONS FOR BENEFITS

- 4.1 Payment will not be made for any services provided to a Member unless such service is listed and described in Attachment D. If a Member has any question as to whether or not a specific service is covered, he or she should call UnitedHealthcare at the toll-free telephone number listed in Attachment C.
- 4.2 All services, whether provided by a Participating or a Non-Participating Provider, are subject to evaluation by UnitedHealthcare for appropriateness of care and case management if necessary.
- 4.3 Benefits will be paid only for a service, procedure, treatment, supply, device, or item, Hospital, medical or otherwise, which is medically necessary. To be medically necessary the service or treatment must meet the following criteria as determined by UnitedHealthcare and, if required by UnitedHealthcare, must be authorized on a prospective and timely basis by UnitedHealthcare:
- 4.3.1 The service or treatment is consistent with generally accepted principles of medical practice for the diagnosis and treatment of the Member's medical condition; and
- 4.3.2 The service or treatment is performed in the most cost-effective manner in terms of treatment, method, setting, frequency and intensity, taking into consideration the Member's medical condition.
- 4.4 UnitedHealthcare has the right to require Preauthorization in regard to any service provided by a Participating or Non-Participating Provider. Preauthorization requirements are set forth in section 6.1.1.
- 4.5 While a Member may consult with a Physician or other Provider about treatment which is excluded in Article 8 of this Contract or otherwise not covered, should the Member decide to follow a course of treatment which is excluded or not covered, UnitedHealthcare will not pay for such treatment.

ARTICLE 5 – SCHEDULE OF BENEFITS

- 5.1 Benefits listed under this Article will be paid subject to the provisions of Attachment D.
- 5.1.1 **Participating Provider.** The “In-Network” level of benefits will be paid when Covered Services are provided by a Participating Provider.
- 5.1.2 **Non-Participating Provider – Medical Emergency.** Covered Services from a Non-Participating Provider due to a Medical Emergency will be paid at the “In-Network” level of benefits shown in Attachment D.
- 5.1.3 **Non-Participating Provider – Non-Emergency.** Non-emergency Covered Services from a Non-Participating Provider will be paid at the “Out-of-Network” level of benefits shown in Attachment D.
- 5.2 **Preventive Care Examinations and Associated Services.** Benefits are available for Preventive Care examinations (well-baby, well-child, well-adult care) and associated services including, but not limited to, immunizations to prevent or arrest the further manifestation of human illness or injury, laboratory testing or screening, x-rays, uterine cervical-cytological testing (Pap testing) and low-dose mammography testing. “Preventive Care” refers to examinations and services recommended by the U.S. Preventive Services Task Force or preventive care services mandated by state or federal law or regulation.
- 5.3 **Physician Medical Services.** Benefits are available for the following services when performed for the treatment of illness or injury:
- 5.3.1 Office visits.
- 5.3.2 Office consultations.
- 5.3.3 Injections which are not usually self-administered.
- 5.3.4 Surgical care and associated anesthesia, including maternity care.
- 5.3.5 X-ray and laboratory tests and services, including pathology services and radiation therapy, for the treatment of illness or injury.
- 5.3.6 Blood transfusion services.
- 5.3.7 Hospital visits, Skilled Nursing Facility visits, and home visits.
- 5.3.8 Newborn care from the moment of birth, including well-care and care for the treatment of illness, injury, congenital defects, birth abnormalities and premature birth.
- 5.3.9 Casts and dressings
- 5.3.10 Medical eye exams (refer to section 8.10 for exclusions)
- 5.3.11 All covered medical supplies furnished in connection with the services provided above.
- 5.4 **Allergy Testing and Injections.** Benefits are available as described in Attachment D.
- 5.5 **Inpatient Services.** Benefits are available for services received in an acute care Hospital or Skilled Nursing Facility for room and board at the semi-private or intensive care level, less any applicable

Copayment, Coinsurance, or Deductible. For a private room, the Member shall pay directly to the facility the difference between its regular charge for the private room and its most common charge for a semi-private room, as well as any applicable Copayment, Coinsurance, or Deductible. However, if a private room is authorized as medically necessary by UnitedHealthcare, then the private room charge shall be covered, less any applicable Copayment, Coinsurance, or Deductible. Room and board includes all charges made by a Hospital on its own behalf for the room, meals, and for all general services and activities needed for the care of a registered bed patient. Also covered are the miscellaneous medical services and supplies used during the confinement such as, but not limited to, diagnostic x-rays and laboratory tests, and the administration of anesthesia, whole blood and blood derivatives.

In an intensive care unit, a Member shall be entitled to all services of the intensive care unit.

5.6 **Outpatient Hospital and Ambulatory Care Services.** Charges incurred as a result of surgery performed as an outpatient or in an ambulatory care setting are covered.

5.7 **Emergency Services.** Whenever possible, a Member should contact his or her Physician prior to receiving treatment for a Medical Emergency. If the Physician is not immediately available, the Member should seek emergency care at the most convenient health care facility.

5.7.1 **Emergency Services.** When a Medical Emergency occurs, the Member should seek care immediately from a Hospital or other emergency facility. If it is determined that a Medical Emergency existed, or that the visit to the Hospital or other emergency facility was medically necessary, the initial visit will be covered. Follow-up care received in a Hospital or an emergency facility is not covered; the Member must arrange follow-up care with a Physician.

5.7.2 **Determination of Covered Benefits.** The determination of covered benefits for services rendered in a Hospital or emergency facility is based on UnitedHealthcare's review of the Member's emergency room medical records, along with those relevant symptoms and circumstances that preceded the provision of care. If it is determined that a Medical Emergency did not exist, or that services were not medically necessary, the Member will be held financially responsible for those services. As a general rule, for UnitedHealthcare to determine that a Medical Emergency existed or that services were medically necessary, the date of the onset of symptoms and the date of treatment as reported on the claim form should be the same but not more than 24 hours after an illness or injury.

5.7.3 **Notification After Services are Received.** If due to the severity of his or her condition, the Member was unable to notify his or her Physician prior to seeking emergency care, the Member should notify his or her Physician within 48 hours after treatment is rendered, or as soon as reasonably possible. If the Member is unable to notify due to his or her condition, or if the patient is a minor, this 48-hour period will be reasonably extended until the Member or a responsible adult is able to notify.

5.8 **Ambulance Services.** For Medical Emergencies, ambulance services will be covered to the nearest facility that is equipped and staffed to provide necessary services. Preauthorization is not required to access an emergency 911 system or other state, county or municipal emergency medical system for ambulance services. For non-emergencies, when medically necessary, a Member shall be entitled to coverage for ambulance services to a Hospital, between Hospitals when needed specialized care cannot be obtained at the first Hospital, and between a Hospital and a Skilled Nursing Facility.

5.9 **Home Health Services.** A Member confined to his or her home may be entitled to skilled nursing services provided by a Home Health Agency. Such visits shall include part-time or intermittent home health care by or under the supervision of a registered nurse. A skilled nursing visit of four hours or less shall equal one home health visit. Before Home Health Services are rendered, Preauthorization must be obtained from UnitedHealthcare, as described in section 6.1.1.

5.10 **Hospice Services.** Benefits are provided for outpatient Hospice Services to a Member with a Terminal Illness. Before Hospice Services are rendered, Preauthorization must be obtained from UnitedHealthcare, as described in section 6.1.1.

5.10.1 For the purposes of this section, the following definitions apply:

5.10.1.1 “Hospice Services” means a coordinated program of outpatient care provided directly by or under the direction of a Medicare-certified hospice agency or Medicare-certified home health agency, and includes Palliative Care and supportive physical, psychological, psychosocial and other health services, utilizing a medically-directed interdisciplinary team.

5.10.1.2 “Member with a Terminal Illness” means a Member whose condition has been diagnosed as terminal by a licensed Physician, whose medical prognosis is death within six months, and who has elected to receive Palliative Care rather than curative care.

5.10.1.3 “Palliative Care” means treatment directed at controlling pain, relieving other symptoms, and focusing on the Member’s special needs while experiencing the stress of the dying process, rather than treatment aimed at investigation and intervention for the purpose of curing or of prolonging life.

5.10.2 There may be clinical situations when short episodes of acute care would be appropriate even when the Member remains in the hospice setting. While these acute care services are not payable under the Hospice Services benefit, they may be Covered Services under other sections of this Contract.

[5.10.3 **Exclusion applicable to Hospice Services.** Charges for room and board are specifically excluded from the Hospice Services benefit. If a Member receives Hospice Services in his or her home, or while living in a nursing home or residential facility, room and board will not be covered under this Contract.]

5.11 **Durable Medical Equipment.** Benefits are payable for the rental of Durable Medical Equipment for home use in the treatment of an injury or illness or for the improvement of the function of a malformed body member. In some cases, UnitedHealthcare may determine that purchase of the equipment is more appropriate than rental. Benefits will not be paid for special features or equipment requested by the Member for personal comfort or convenience.

“Durable Medical Equipment” means medical equipment that (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) is not useful in the absence of illness or injury, and (d) is appropriate for home medical treatment.

5.12 **Prosthetic Devices and Services.** Benefits are available for the evaluation and treatment of a condition that requires the use of a Prosthetic Device. Benefits are available for Prosthetic Devices that restore physiological function or cosmesis to the member. If more than one Prosthetic Device can meet the member’s functional needs, benefits are available only for the Prosthetic Device that meets the minimum specifications for the member’s needs. If the member should purchase a Prosthetic Device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the orthotic that meets the minimum specifications, and the member will be responsible for paying any difference in cost.

The Prosthetic Device must be ordered or provided by, or under, the direction of a Physician. Benefits are available for repairs and replacement when necessitated by anatomical change or normal use but is otherwise limited to one (1) time every (3) years unless medically necessary, except that:

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

Prosthetic Devices do not include an artificial eye, an artificial ear, a dental appliance, a cosmetic device such as artificial eyelashes or wigs, a device used exclusively for athletic purposes, an artificial facial device, or other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

- 5.13 **Organ and Tissue Transplants.** Organ and tissue transplant services described in this section must be ordered by the Member's Attending Physician and received from transplant centers approved by UnitedHealthcare; otherwise, benefits will not be paid. [Before organ and tissue transplant services are rendered, Preauthorization must be obtained from UnitedHealthcare, as described in section 6.1.1.]

Benefits for all organ and tissue transplant services will be payable as shown in Attachment D. This restriction applies to all services performed in conjunction with the transplant. Transplant services for a Member who is the recipient of an organ or tissue transplant include all professional, technical and facility charges (inpatient and outpatient) for evaluation of the transplant procedure and follow-up care (twelve months). If the recipient is a Member, professional, technical and facility charges for removal of the donated organ or tissue, as well as any complication resulting from the donation, are also covered by UnitedHealthcare for a live primary donor up to 90 calendar days after the date of the donation, if such donation is not covered by other insurance. Organ and tissues covered for transplant include: heart, heart/lung, kidney, kidney/pancreas, liver, lung, bone marrow and stem cell.

If a Member is registered at two or more transplant centers for the same transplant (i.e. "multiple listing"), UnitedHealthcare will pay for Covered Services associated with only one approved transplant center waiting list. UnitedHealthcare will not pay for any charges related to additional transplant center waiting lists.

UnitedHealthcare has specific guidelines regarding benefits for transplant services. The Member should contact UnitedHealthcare at the telephone number on the back of the ID card for information about these guidelines.

- 5.14 **Cornea Transplants.** Benefits are available as described in Attachment D.

- 5.15 **Temporomandibular Joint Syndrome.** Diagnosis and surgical treatment of temporomandibular or craniomandibular joint syndrome or disorders (hereafter called 'TMJ syndrome'), which is due to a medical condition or injury that prevents normal function of the joint or bone and is medically necessary to attain functional capacity of the affected part, will not be more limited or restricted than coverage applicable for such treatment involving any bone or joint of the skeletal structure.

- 5.16 **Outpatient Rehabilitative Therapy.** Outpatient rehabilitative therapy benefits will be paid for conditions resulting from disease or injury or when prescribed immediately following surgery related to the condition. Outpatient rehabilitative therapy includes physical, occupational, and speech therapy and cardiac (phase I and II) and pulmonary rehabilitation. Therapy must be ordered by a Physician and performed by a licensed therapist acting within the scope of his or her licensure.

5.16.1 Occupational therapy shall not include vocational therapy, vocational rehabilitation, educational or recreational therapy. Occupational therapy performed by an occupational therapist will be covered to the extent that such therapy is performed to regain use of the upper extremities.

5.16.2 Speech and hearing therapy will be covered only for treatment of a residual speech or hearing impairment resulting from a stroke, accidental injury or surgery to the head or neck or for treatment of a communicative disorder.

5.16.3 Cardiac rehabilitation requires continuous ECG monitoring to be covered. Only monitored (Phase I and II) cardiac rehabilitation is covered.

- 5.16.4 Pulmonary rehabilitation program is payable once per lifetime for a Member. [Pulmonary rehabilitation does not count toward any applicable maximum number of Outpatient Rehabilitative Therapy treatment visits shown in Attachment D.]
- 5.17 **X-ray and Laboratory Services.** Benefits are payable for diagnostic x-ray and laboratory services performed for the diagnosis and/or treatment of an illness or injury, including, but not limited to, x-ray films and scans, such as computerized axial tomography (CAT) scans, electrocardiograms (EKGs), ultrasound examinations, mammography, and blood, urine and pathology (tissue) tests.
- 5.18 **Radiation Therapy and Chemotherapy.** Benefits are payable for radiation therapy (such as x-ray and radium) received in connection with the treatment of malignancies and certain other tumors; and generally accepted chemotherapy received for the treatment of malignancies.
- 5.19 **Renal Dialysis Services.** Benefits are available as described in Attachment D.
- 5.20 **Mental Health Services.** Benefits for Hospital Services or medical care for mental health shall be covered, and coverage will be neither different nor separate from coverage for any other illness, condition, or disorder, for the purposes of determining any limitations and Deductible, Copayment, and Coinsurance. Any day of confinement, service provided, or examination must have Preauthorization from UnitedHealthcare's mental health treatment program provider, except when a Medical Emergency exists. The Member may contact UnitedHealthcare's mental health treatment program provider at the toll-free telephone number listed on the back of the Member's UnitedHealthcare identification card to request a list of Participating Providers or for more information on the procedures to be followed.
- 5.20.1 **Inpatient Facility Services.** If a Member is confined as a resident inpatient in a Hospital, Non-Acute Hospital, or other residential treatment facility and enrolled in a treatment program for a psychiatric, mental, or nervous condition or disorder, benefits will be paid according to the provisions of Attachment D and section 5.5.
- 5.20.2 **Outpatient Facility Services.** Outpatient facility service benefits will be paid if a Member receives Hospital outpatient medical services at a Hospital, Non-Acute Hospital, or other treatment facility and is enrolled in an outpatient treatment program for a psychiatric, mental, or nervous condition or disorder. Benefits will be paid according to the provisions of Attachment D and section 5.6.
- “Non-Acute Hospital” as used in this section means a facility which is not licensed to operate as an acute care general Hospital.
- 5.20.3 **Physician Services.** If a Member shall receive psychiatric or professional services by a Physician acting within the scope of his or her licensed authority, or other licensed mental health Provider, for a psychiatric, mental or nervous condition or disorder, benefits will be paid subject to Attachment D and the following provisions:
- 5.20.3.1 **Hospital Inpatient Physician Services.** Hospital inpatient Physician services benefits will be paid if the Member is confined as a resident inpatient in a Hospital as described in section 5.5.
- 5.20.3.2 **Hospital Outpatient Physician Services.** Hospital outpatient Physician services benefits will be paid if the Member receives Hospital outpatient services as described in section 5.6.
- 5.20.3.3 **Physician Office Services.**
- 5.20.4 **Exclusions and Limitations Applicable to Mental Health Benefits.** See section 8.43.

- 5.21 **Substance Abuse Services.** Benefits for Hospital Services or medical care for substance abuse including alcoholism shall be covered, and coverage will be neither different nor separate from coverage for any other illness, condition, or disorder, for the purposes of determining any limitations and Deductible, Copayment, and Coinsurance. Any day of confinement, service provided, or examination must have Preauthorization from UnitedHealthcare's substance abuse treatment program provider, except when a Medical Emergency exists. The Member may contact UnitedHealthcare's substance abuse treatment program provider at the toll-free telephone number listed on the back of the Member's UnitedHealthcare identification card to request a list of Participating Providers or more information on the procedures to be followed.
- 5.21.1 **Inpatient Facility Services.** If a Member is confined as a resident inpatient in a Hospital, Non-Acute Hospital, or other residential treatment facility and enrolled in a treatment program for substance abuse, benefits will be paid according to the provisions of Attachment D and section 5.5.
- 5.21.2 **Outpatient Facility Services.** Outpatient facility service benefits will be paid if a Member receives Hospital outpatient medical services at a Hospital, Non-Acute Hospital, or other treatment facility and is enrolled in an outpatient treatment program for substance abuse. Benefits will be paid according to the provisions of Attachment D and section 5.6.
- “Non-Acute Hospital” as used in this section means a facility which is not licensed to operate as an acute care general Hospital.
- 5.21.3 **Physician Services.** If a Member shall receive psychiatric or professional services by a Physician acting within the scope of his or her licensed authority, or other licensed mental health Provider, for substance abuse, benefits will be paid subject to Attachment D and the following provisions:
- 5.21.3.1 **Hospital Inpatient Physician Services.** Hospital inpatient Physician services benefits will be paid if the Member is confined as a resident inpatient in a Hospital as described in section 5.5.
- 5.21.3.2 **Hospital Outpatient Physician Services.** Hospital outpatient Physician services benefits will be paid if the Member shall receive Hospital outpatient services as described in section 5.6.
- 5.21.3.3 **Physician Office Services.**
- 5.21.4 **Exclusions and Limitations Applicable to Substance Abuse Benefits.** See section 8.43.
- 5.22 **Reconstructive Surgery.** Benefits are provided for reconstructive surgical procedures which are medically necessary to repair a functional disorder as a result of disease, injury or congenital anomaly. Benefits are also provided for: all stages of reconstructive breast surgery as a result of a mastectomy; reconstructive surgery necessary to re-establish symmetry between the two breasts; prostheses; and treatment of physical complications including treatment of lymphedemas at all stages of the mastectomy. Benefits for reconstructive surgery as a result of a mastectomy are provided in a manner determined in consultation with the attending Provider and the patient.
- 5.23 **Maternity Care.** Benefits are provided for maternity care, including prenatal and post-natal care and care for complications of pregnancy. With regard to post-parturition care, coverage is as follows: (a) a minimum of 48 hours of inpatient care for the mother and newborn, following a vaginal delivery, or (b) a minimum of 96 hours of inpatient care for the mother and newborn, following a delivery by caesarian section. A shorter length of stay for services related to maternity and newborn care may be provided if after consultation with the mother or upon consent of the mother the Attending Physician determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics, that the mother and the newborn meet the appropriate guidelines for that length of stay based upon evaluation of the mother and newborn. If a shorter length of stay is determined to

be appropriate in accordance with these guidelines, the mother and newborn shall have coverage for an office visit or home-nurse visit within 48 hours of discharge.

Diabetes Self-Management Training is mandated in Arkansas.

Use this verbiage if the hybrid prescription drug rider is purchased:

[5.24 **Diabetes Self-Management/Supplies.** Benefits are provided for equipment and supplies (including, but not limited to, blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, and lancets). Outpatient self-management training and education must be provided in person by a certified, registered, or licensed health care professional. Note that benefits for diabetic equipment and supplies are provided and paid through a supplemental benefits rider for prescription drugs attached hereto.]

Use this verbiage if the hybrid prescription drug rider is not purchased

[5.24 **Diabetes Self-Management/Supplies.** Benefits are provided for equipment and supplies (including, but not limited to, blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, and lancets). Outpatient self-management training and education must be provided in person by a certified, registered, or licensed health care professional. Note that benefits for diabetic equipment and supplies will be paid according to the Durable Medical Equipment provisions of Attachment D.]

5.25 **Certain Clinical Trials for Treatment Studies on Cancer approved by National Cancer Institute (NCI) or National Institutes of Health (NIH).**

5.25.1 Coverage is provided for Patient Costs, as defined below, incurred by Member during participation in any phase of clinical trials for treatment studies on cancer but only when all of the following conditions are met:

5.25.1.1 There is no clearly superior, non-investigational treatment alternative;

5.25.1.2 The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative;

5.25.1.3 The Member and Member's Attending Physician conclude that the Member's participation in the clinical trial would be appropriate;

5.25.1.4 The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and expertise; and

5.25.1.5 The treatment is provided by a clinical trial approved by one of the following: (a) the NCI, (b) an NCI Cooperative Group, or (c) an NCI center or the federal Department of Veterans Affairs. "Cooperative Group" means a formal network of facilities that collaborate on research projects and have an established NCI-approved peer review program operating within the group. Cooperative Group includes the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program.

5.25.2 Coverage of Patient Costs incurred during participation in a clinical trial shall be determined in the same manner as reimbursement is determined for other medical and surgical procedures.

5.25.3 "Patient Costs" means the costs of Covered Services that are incurred as a result of the treatment being provided to Member for purposes of a clinical trial. Patient Costs do not include:

5.25.3.1 the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial;

5.25.3.2 costs associated with managing the research associated with the clinical trial;

- 5.25.3.3 the cost of the investigational procedure, drug, pharmaceutical, device, or clinical trial therapies, regimens, or combinations thereof;
- 5.25.3.4 costs associated with the provision of any goods, services, or benefits that are generally furnished without charge in connection with an approved clinical trial program for treatment of cancer;
- 5.25.3.5 additional costs associated with the provision of any goods, services, or benefits that previously have been provided to, paid for, or reimbursed, or any similar costs; or
- 5.25.3.6 treatments or services prescribed for the convenience of the Member or his or her Attending Physician.

5.26 **General Anesthesia for Dental Procedures.** Benefits are payable for general anesthesia and Hospital or ambulatory surgical treatment center charges for dental treatment care if any of the following applies:

- 5.26.1 Member is age 8 years or younger;
- 5.26.2 Member is Disabled (see definition below); or
- 5.26.3 As used in section 5.26.2 above, “Disabled” means a person of any age with a chronic disability which meets all of the following conditions: (a) it is attributable to a mental or physical impairment or combination of mental and physical impairments; (b) it is likely to continue; and (c) it results in substantial functional limitations in one or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, capacity for independent living, or economic self-sufficiency.

[5.26.4 Benefits under section 5.30 are subject to any limitation, exclusion, Copayment, Coinsurance, Deductible, or Penalty provision which applies generally under this Contract.]

[5.26.4 Benefits under section 5.30 are subject to any limitation, exclusion, Copayment, Coinsurance, or Deductible provision which applies generally under this Contract.]

5.27 **Hearing Aids.** Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Participating Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing. Hearing aids are required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier, and receiver.

5.28 **Urgent Care Facility Services.** Services received at an Urgent Care Facility are available as described in Attachment D.

[5.29 **Spinal Manipulative Services.** Benefits will be payable for Members for spinal manipulative services provided by a licensed Doctor of Chiropractic (D.C.). Services covered are diagnostic evaluation and x-ray services for the purpose of diagnosing the appropriateness of spinal manipulation treatment, diathermy, electric stimulation, emergency room, massage, medical supplies, office visits, spinal manipulation, traction, and ultrasound. [Benefits payable for these services do not apply toward any Outpatient Rehabilitative Therapy limits as defined in Attachment D.] Network Services are provided by a Network Provider who has entered into an agreement with ACN Group, Inc. (ACN) for UnitedHealthcare. Services are subject to preauthorization by ACN. Services provided by a Non-Network Provider [must be preauthorized by ACN and] will be paid according to Attachment D.]

Bracketed language will be used for HDHP plans

[5.29 **Spinal Manipulative Services.** Benefits will be payable for Members for spinal manipulative services

provided by a licensed Doctor of Chiropractic (D.C.). Services covered are diagnostic evaluation and x-ray services for the purpose of diagnosing the appropriateness of spinal manipulation treatment, diathermy, electric stimulation, emergency room, massage, medical supplies, office visits, spinal manipulation, traction, and ultrasound. [Benefits payable for these services do not apply toward any Outpatient Rehabilitative Therapy limits as defined in Attachment D.]

[5.29.1 **Exclusions Applicable to Spinal Manipulative Services:** See section [8.45].]

[5.30] **Morbid Obesity Surgery.** Surgical treatment and associated care for the treatment of obesity if Preauthorization is obtained from UnitedHealthcare as described in section 6.1.1.]

[5.31] **In Vitro Fertilization Services.** Covered Services for in vitro fertilization services. Cryopreservation, the procedure whereby embryos are frozen for late implantation, will be included as an in vitro fertilization procedure. The coverage will include services performed at:

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

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

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

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

[5.34] **Orthotic Devices and Services.** Benefits are available for the evaluation and treatment of a condition that requires the use of an Orthotic Device. Benefits are available for external Orthotic Devices that restore physiological function or cosmesis. If more than one orthotic device can meet the Member's functional needs, benefits are available only for the orthotic device that meets the minimum specifications for the Member's needs. If the Member purchases an Orthotic Device that exceeds these minimum specifications, UnitedHealthcare will pay only the amount that UnitedHealthcare would have paid for the orthotic that meets the minimum specifications, and the Member will be responsible for paying any difference in cost.

The Orthotic Device must be ordered or provided by, or under the direction of a Physician. Benefits are available for repairs and replacement when necessitated by anatomical change or normal use but is otherwise limited to one (1) time every (3) years unless medically necessary except that:

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

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

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

ARTICLE 6 – MEDICAL MANAGEMENT PROCESSES

- 6.1 UnitedHealthcare utilizes the following medical management processes for services from Participating and Non-Participating Providers:
- 6.1.1 **Preauthorization.** Some services, items, and procedures, including certain medical and diagnostic procedures, require approval by UnitedHealthcare prior to the time those services, items, and procedures are furnished (“Preauthorization”). UnitedHealthcare establishes the criteria used to determine the appropriateness of the services, items, and procedures and the level of care that will be covered.
- 6.1.1.1 *When a Member uses Participating Providers:* The Member *is not* responsible for obtaining Preauthorization. Participating Providers are responsible for complying with Preauthorization requirements.
- 6.1.1.2 *When a Member uses Non-Participating Providers:* The Member *is* responsible for obtaining Preauthorization.
- 6.1.1.3 *When a Member fails to obtain Preauthorization:* If the Member fails to obtain Preauthorization for services, items, or procedures from Non-Participating Providers, and UnitedHealthcare determines the services, items, or procedures were medically necessary, the services, items, or procedures will be covered, but the Member will pay a Penalty, in addition to any applicable Deductible and/or Coinsurance, as set forth in Attachment D. Any Penalty amount paid by the Member will not count toward any applicable Deductible or Maximum Out-of-Pocket Expense. If UnitedHealthcare determines that the services, items, or procedures were not medically necessary, the Member will be responsible for paying the Non-Participating Provider all charges for such services, items, and procedures.
- 6.1.1.4 If a Member has any question as to whether or not a service, item, or procedure requires Preauthorization, the Member should call UnitedHealthcare at the toll-free telephone number listed in Attachment C, or visit the UnitedHealthcare web site also listed in Attachment C.
- 6.1.1.5 When Preauthorization is required prior to rendering treatment, UnitedHealthcare will have personnel available to provide such Preauthorization.
- 6.1.1.6 Section 6.1.1 also applies to mental health and substance abuse services, as described in sections 5.20 and 5.21, with the following exception: Preauthorization must be obtained from UnitedHealthcare’s mental health and/or substance abuse treatment program provider. The toll-free telephone number for UnitedHealthcare’s mental health and/or substance abuse treatment program provider is listed on the back of the Member’s UnitedHealthcare identification card.
- 6.1.2 **Hospital or Nursing Facility Continued Stay Review.** Continued stays at a facility may be reviewed for appropriateness of care and services. This review will be performed by UnitedHealthcare. If a continued stay is determined by UnitedHealthcare to be no longer medically necessary, UnitedHealthcare may contact the Attending Physician to determine the need for the continued stay and request a plan of treatment. Any charges for services provided following the determination by UnitedHealthcare that services are not medically necessary will not

be paid by UnitedHealthcare and will not be counted toward any applicable Deductible or Maximum Out-of-Pocket Expense limits.

- 6.1.3 **Case Management.** UnitedHealthcare may engage in the medical management of certain treatment of Members from time to time to help assure that appropriate health care is being provided to the Member. This medical management may also coordinate various aspects of care provided to seriously ill or injured Members.

ARTICLE 7 - MEMBER PAYMENTS DIRECTLY TO PROVIDERS

- [7.1 If any services not included in or covered by this Contract are provided to a Member, or if any Copayments, Coinsurance, Deductibles, and/or Penalty amounts apply as shown in Attachment D, the Member shall make direct payment to the Provider of such services.]
- [7.1 If any services not included in or covered by this Contract are provided to a Member, or if any Copayments, Coinsurance, and/or Deductibles apply as shown in Attachment D, the Member shall make direct payment to the Provider of such services.]

ARTICLE 8 - EXCLUSIONS APPLICABLE TO THE CONTRACT

In addition to specific exclusions listed under individual Articles, benefits shall not be provided for any of the following:

- 8.1 Any service or treatment, Hospital, medical, or otherwise, which is not medically necessary as described and defined in section 4.3, or any medical complication resulting from a service, treatment, procedure, or device which is not covered under this Contract .
- 8.2 Shift care, 24-hour nursing, or private duty nursing services in the Hospital, home or Skilled Nursing Facility.
- 8.3 Care for conditions that federal, state or local law requires be treated in a public facility, Hospital, or other health care facility.
- 8.4 If the Member's condition is custodial, which means that his or her care consists of watching, maintaining, protecting or is for the purpose of providing personal needs, UnitedHealthcare does not pay for a person or facility to provide any of, but not limited to, the following:
- 8.4.1 assistance in the activities of daily living, such as walking, dressing, getting in and out of bed, bathing, eating, feeding or using the toilet or help with other functions of daily living or personal needs of a similar nature;
 - 8.4.2 changes of dressings, diapers, protective sheets or periodic turning or positioning in bed;
 - 8.4.3 administration of or help in using or applying medications, creams and ointments, whether oral, inhaled, topical, rectal or injection;
 - 8.4.4 administration of oxygen;
 - 8.4.5 care or maintenance in connection with casts, braces, or other similar devices;
 - 8.4.6 care in connection with ostomy bags or devices or in-dwelling catheters;
 - 8.4.7 feeding by tube including cleaning and care of the tube site;

- 8.4.8 tracheostomy care including cleaning, suctioning and site care;
 - 8.4.9 urinary bladder catheterization;
 - 8.4.10 monitoring, routine adjustments, maintenance or cleaning of an electronic or mechanical device used to support a physiological function including, but not limited to, a ventilator, phrenic nerve or diaphragmatic pacer; or
 - 8.4.11 general supervision of exercise programs including carrying out of maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitation services.
- 8.5 Hospital, personal care or convenience items or services including, but not limited to: television, telephone, newborn infant photos, complimentary meals, birth announcements, or other articles which are not for specific treatment of illness or injury. Also, benefits are not provided for:
- 8.5.1 private room or special diets unless medically necessary;
 - 8.5.2 housekeeping, homemaker service, and caregiver room/board;
 - 8.5.3 purchase or rental of household equipment or fixtures such as air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses, waterbeds, escalators, elevators, saunas, or swimming pools; or
 - 8.5.4 charges for diversional activities such as recreational, hobby or craft equipment or fees.
- 8.6 Surgical excision or reformation of any sagging skin on any part of the body including but not limited to eyelids, face, neck, abdomen, arms, legs, or buttocks [unless determined medically necessary in accordance with section 5.30]; any services performed in connection with enlargement, reduction, implantation, or change in appearance in any portion of the body including but not limited to, breasts, face, lips, jaw, chin, nose, ears or genitals; hair transplantation; chemical face peels or abrasions of skin; electrolysis depilation; treatment of birthmarks or superficial veins; any other surgical or non-surgical procedures which are performed for cosmetic purposes. However, benefits will be payable for certain reconstructive surgery as described in section 5.22.
- 8.7 Any fees for the services of Providers that are not Physicians if the fees or charges therefore are claimed by Hospitals, laboratories, or other institutions or for the service of any assisting Physician not authorized by a Provider.
- 8.8 Dental care.
- 8.8.1 Any fees involving any types of services in connection with dentistry are excluded, including but not limited to:
 - 8.8.1.1 the care, filling, removal or replacement of teeth or of the structures supporting the teeth;
 - 8.8.2 Exceptions to this exclusion are as follows:
 - 8.8.2.1 Reconstructive surgery as provided in section 5.22;
 - 8.8.2.2 General anesthesia for dental procedures as provided in section 5.26;
 - 8.8.2.3 Surgical and non-surgical procedures resulting directly from: (a) neoplasms that require treatment to the jaws, cheeks, lips, tongue, or roof or floor of mouth; or (b) accidental

injury to natural permanent teeth for which the Member seeks treatment within 60 days of the injury. "Injury" does not include fractures of restorations or teeth resulting from routine daily functions. Preauthorization is required prior to any such treatment, procedure or service described in this section;

8.8.2.4 If dental coverage is provided in a supplemental benefits rider attached hereto; or

8.8.2.5 Coverage for treatment of temporomandibular or craniomandibular joint syndrome (TMJ) as described in section 5.15.

8.9 The following items, unless provided in a supplemental benefits rider attached hereto:

8.9.1 dental prostheses; or

8.9.2 eye glasses or contact lenses

8.10 Routine eye examinations or refractions, including examinations for astigmatism, myopia, or hyperopia, unless a supplemental benefits rider is attached hereto.

8.11 Augmentative communication devices, unless medically necessary.

8.12 Special shoes unless an integral part of a brace or part of diabetes treatment; corrective footwear; routine foot care, including trimming of corns, calluses and nails unless part of diabetes treatment; corsets, other articles of clothing, or cosmetic devices.

8.13 Treatment provided in a government Hospital; services performed by a Member for a Member's immediate family; and services for which no charge is normally made.

8.14 Services for any illness, injury or disease that is covered, in whole or in part, by any employer's plan or coverage designed to comply with any state or federal workers' compensation, employer's liability or occupational disease law (collectively, workers' compensation law), or, with respect to the Subscriber, any illness, injury or disease that could be covered, in whole or in part, by such plan or coverage if the employer is required by applicable federal, state, or local law to have such plan or coverage. If UnitedHealthcare makes payment for such services, it shall be entitled to a lien upon any amounts it paid for which the employer's workers' compensation plan or coverage should have been liable.

8.15 Any service which can be performed in the setting by a person who does not have professional qualifications but has been trained to perform the service.

8.16 Experimental and/or investigational drugs, devices, medical treatment or procedures.

8.16.1 A drug, device, treatment or procedure is experimental and/or investigational if:

8.16.1.1 the drug or device requires approval of the Food and Drug Administration and the drug or device has not been approved when furnished (a drug or device approved for experimental and/or investigational use is deemed to be experimental and/or investigational) except that coverage is provided for a drug which has been prescribed for a treatment for which the drug has not been approved by the FDA, provided the drug is recognized for the specific treatment for which the drug has been prescribed in one of the following established reference compendia: (1) the *U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional* (USPDI); (2) the *American Medical Association's Drug Evaluations* (AMADE); or (3) the *American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information* (AHES-DI) or, it is recommended by a clinical study or review article in a major peer reviewed professional journal. However, there is not coverage for any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been

prescribed. For purposes of any drug approved by the Food and Drug Administration for the treatment of cancer, the following standard reference compendia shall apply: (1) The American Hospital Formulary Service Drug Information; (2) The National Comprehensive Cancer Network Drugs and Biologics Compendium; (3) The Elsevier Gold Standard's Clinical Pharmacology; or the drug has been recognized as safe and effective for treatment of that specific type of cancer in two (2) articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature or other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services or the commissioner may be used to provide coverage to a Member at UnitedHealthcare's discretion.

8.16.1.2 the drug, device, treatment or procedure is being provided according to a written protocol which describes as an objective determining the safety, toxicity, efficacy or effectiveness of the drug, device, treatment, or procedure as compared with the standard means of treatment or diagnosis for the Member's medical condition; or

8.16.1.3 Reliable Evidence shows that the consensus of opinion among experts regarding the drug, device, treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis for the Member's medical condition.

8.16.2 For the purposes of this Article, "Reliable Evidence" shall mean only published reports and articles in the authoritative medical and scientific literature.

8.16.3 Treatment provided in a phase I, II, or III clinical trial will be deemed to be experimental and/or investigational unless Reliable Evidence establishes that the treatment is not experimental and/or investigational for the Member's medical condition. Exception: "Patient Costs" incurred as a result of a Member's participation in certain National Cancer Institute-approved and National Institutes of Health-approved clinical trials for cancer are covered as described in section 5.25.

8.17 Biofeedback treatment except in conjunction with physical therapy performed for the treatment of urinary incontinence.

8.18 Holistic medicine; massage therapy; acupuncture; hypnotherapy; sleep therapy; vocational, rehabilitational or employment counseling; marriage and sex counseling; behavior training, conduct disorders and related family counseling; remedial education and treatment of learning disabilities.

8.19 Charges of a Non-Participating Provider in excess of the [MNRP rate][Maximum Allowance], unless due to a Medical Emergency.

8.20 Drugs, medicines, or any implants or devices used in conjunction with birth control regardless of the intended use, unless provided in a supplemental benefits rider attached hereto.

8.21 Ergometers, exercise bikes, or other similar devices.

8.22 Diet or weight loss programs, nutritional counseling, dietary supplements, nutritional formulas and supplements, and megavitamin therapy. Exceptions to this exclusion are as follows:

8.22.1 Medical nutritional therapy will be covered for up to two medically necessary visits per calendar year for hypertension and myocardial infarction; or

8.22.2 Medical nutritional therapy will be covered under a diabetes self-management program as described in section 5.24.

- 8.23 Illness contracted or injuries sustained as the result of war, declared or undeclared, or any act or hazard of war.
- 8.24 Illness contracted or injuries sustained as the result of or while in the armed services of any country to the extent that the Member is entitled to coverage for such sickness or injury through any governmental plan or program except Medicaid.
- 8.25 Outpatient prescription drugs unless a supplemental benefits rider is attached hereto, and other drugs or medications except when provided to Member in an inpatient setting.
- 8.26 Hospital or Physician services or treatment provided as a result of a court order unless Preauthorization has been obtained from UnitedHealthcare.
- [8.27 Charges incurred in connection with any assisted reproduction techniques if the reason for the treatment is related to reversal of vasectomies, reversal of tubal ligations or the reversal of other voluntary sterilization procedures.]
- [8.28] Any treatment or procedures related to the performance of gender transformation.
- [8.29] Surgery to the cornea or any other part of the eye to improve vision by changing the refraction, such as but not limited to radial keratotomy or LASIK (laser assisted in-situ keratomileusis).
- [8.30] Physical exams and any related diagnostic testing required for employment, licensing, insurance, adoption, immigration, school, camp or sports participation when services will result in duplication of UnitedHealthcare benefits for preventive care. Immunizations for the purpose of obtaining or maintaining employment are also excluded.
- [8.31] Any fees relating to any types of services or items resulting from an injury sustained as a result of the injury was the Member's commission of, or attempt to commit, a felony.
- [8.32] Performance of an injection by a nurse or Physician which would normally be self-administered, except in an inpatient setting.
- [8.33] Occupational therapy shall not include vocational therapy, vocational rehabilitation, educational or recreational therapy.
- [8.34] Surgical treatment and associated care for treatment of obesity.]
- [8.34] Surgical treatment and associated care for the treatment of obesity, except when Preauthorization is obtained from UnitedHealthcare as described in section 6.1.1]
- [8.35] Organ and tissue transplant services provided by Participating Providers that are not UnitedHealthcare-approved transplant centers or by Non-Participating Providers. Charges associated with more than one transplant center waiting list are also excluded. Organ and tissue transplant services are payable only as described in section 5.13.
- [8.36] Telephone or email consultations, charges for failure to keep scheduled appointments, charges for completion of any form, or charges for copying medical records.
- [8.37] Charges for non-used medication.
- [8.38] Replacement of items that are lost, stolen, misused, otherwise abused, or damaged due to neglect or accident.

[8.39] Charges in excess of any Maximum Policy Benefit amount shown in Attachment D for any Member.

[8.40] Charges in excess of any benefit maximum or limitation shown in Attachment D.

[8.41] The following mental health and substance abuse services:

[8.41.1] services, other than diagnostic services, for mental retardation or for non-treatable mental deficiency;

[8.41.2] treatment of a mental or nervous disorder which is not subject to favorable modification by accepted psychiatric treatment;

[8.41.3] treatment of marital problems;

[8.41.4] family therapy, except as related to a Covered Service for another family member;

[8.41.5] treatment of learning problems;

[8.41.6] treatment of adult or childhood antisocial behavior without manifestation of a psychiatric disorder;

[8.41.7] treatment of aggressive or nonaggressive conduct disorder without manifestation of a psychiatric disorder;

[8.41.8] general counseling and advice;

[8.41.9] charges for personal and convenience items such as telephone, television, personal care items and personal services or for charges for diversional activities such as recreational, hobby or craft equipment or fees; and

[8.41.10] court ordered psychiatric services unless Preauthorization has been obtained from the mental health and/or substance abuse treatment program provider and/or UnitedHealthcare.]

[8.42] Services provided to a Member as part of a demonstration project conducted or sponsored by the Centers for Medicare & Medicaid Services (CMS).

Include if Spinal Manipulative services are purchased by the group

[8.43] [The following spinal manipulative services:

Acupressure, acupuncture, arch supports, biosoterometric studies, cervical pillow, chelation therapy, colonic therapy or irrigations, computerized axial tomography, durable medical equipment, graphic x-ray analysis, hair analysis, hand held doppler, heavy metal screening, iridology, iris analysis, kinesiology, living cell analysis, magnetic resonance imaging, maintenance care, mineral cellular analysis, moiré contourographic analysis, nutritional counseling, nutritional supplements, over-the-counter drugs or preparations, oxygen therapy, Ream's lab or Ream's test, rolfing, sublingual or oral therapy, thermographic procedures, or toxic metal analysis.]

Include if Spinal Manipulative services are not purchased by the group

[8.43] [Manipulative services, unless provided in a Manipulative Services [Addendum][Rider] attached hereto.];]

- [8.44] Cosmetic procedures or services that change or improve appearance without significantly improving physiological function, as determined by UnitedHealthcare.
- [8.45] In the event a Non-Participating Provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.

ARTICLE 9 - GENERAL CONDITIONS UNDER WHICH BENEFITS SHALL BE PROVIDED

- 9.1 The benefits of this Contract are subject to all terms and conditions described herein.
- 9.2 Under this Contract, UnitedHealthcare has the right to make any benefit payment to the Provider of Covered Services, or directly to the Member. UnitedHealthcare is specifically authorized by the Member to determine to whom any benefit payment should be made. In the event a Member has to pay a Non-Participating Provider for Covered Service, at the time services are rendered, UnitedHealthcare will send payment for Covered Service to the Member in accordance with section 11.3, less any applicable [Copayment, Coinsurance, Deductible, and/or Penalty amount] [Copayment, Coinsurance, and/or Deductible].
- 9.3 Hospital Services are subject to all the rules and regulations of the Hospital or Skilled Nursing Facility, including the rules and regulations governing admission and discharge.
- 9.4 The Member agrees that any complaint regarding this Contract or the provision of benefits under this Contract shall be submitted for resolution in accordance with the Member Complaint, Appeal, and Dispute Resolution Procedure established by UnitedHealthcare as set forth in Article 17.
- 9.5 In the event of fraud or misrepresentation of a material fact in enrolling or making claim for benefits under this Contract, including but not limited to the unauthorized use of a Member's UnitedHealthcare identification card by any other person, UnitedHealthcare shall have the right to recover the full amount of any benefits paid on behalf of the Member.
- 9.6 In the event of any major disaster or epidemic, war, riot or labor dispute, UnitedHealthcare shall provide coverage for Hospital Services and medical services covered under this Contract in so far as practical, according to its best judgment, within the limitations of such facilities and personnel as are then available. Under such conditions UnitedHealthcare shall not have any liability or obligation for delay or failure to provide coverage or arrange for Hospital Services or medical services due to lack of available facilities or personnel.
- 9.7 The Member agrees to provide UnitedHealthcare all information relating to duplicate insurance or other coverage for which there may be coordination of benefits.

ARTICLE 10 - RELATIONSHIP AMONG PARTIES AFFECTED BY THE CONTRACT

- 10.1 The relationship between UnitedHealthcare and any person or organization having a contract with UnitedHealthcare is an independent contractor relationship. No such organization or employee or agent thereof is an employee or agent of UnitedHealthcare, and neither is UnitedHealthcare nor any employee or agent of UnitedHealthcare an employee or agent of such organization.
- 10.2 Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services.
- 10.3 The Member is not an agent or representative of UnitedHealthcare, and shall not be liable for any acts or omissions of UnitedHealthcare, its agents or employees, or any other person or organization with which

UnitedHealthcare has made or hereafter shall make arrangements for the performance of services under this Contract.

- 10.4 UnitedHealthcare has entered into a service agreement with its parent UnitedHealthcare Services Company of the River Valley, Inc. which provides all administrative services for UnitedHealthcare.

ARTICLE 11 - CLAIM PROVISIONS

- 11.1 Except as set forth in Attachment D, it is not anticipated that a Member will make payment to any Participating Provider performing a Covered Service under this Contract beyond any applicable Copayment, Coinsurance, or Deductible. However, if the Member furnishes evidence satisfactory to UnitedHealthcare that he or she has made payment to a Participating Provider for performing a Covered Service under this Contract, payment for those charges will be made to the Member, but in no event will the amount of payment to the Member exceed the maximum benefit payable by UnitedHealthcare less any applicable Copayment, Coinsurance, or Deductible.
- 11.2 If a charge is made to a Member by a Participating Provider for performing a Covered Service under this Contract beyond any applicable Copayment, Coinsurance, or Deductible, written proof of such charges should be furnished to UnitedHealthcare within 90 days from the date of service. Payment for such charges will not be made to the Member if evidence of payment is submitted more than fifteen months after the date of service.

Remove this section if assignment of benefits is not permitted.

- [11.3 Charges for a Covered Service performed by a Non-Participating Provider will be paid to the Member, or to the Non-Participating Provider if there is a written assignment of benefits, after written proof of charges is furnished to UnitedHealthcare within [15-24] months from the date the service was performed. Payment for such charges will not be made to the Member, or to the Non-Participating Provider through a written assignment of benefits, if written proof of such charges is not furnished to UnitedHealthcare within this [15-24]-month period.]
- [11.3 Members may not assign benefits under this Contract to a Non-Participating Provider without UnitedHealthcare's consent. When an assignment is not obtained, reimbursement will be sent directly to the Member for reimbursement to a Non-Participating Provider upon receipt of their bill. UnitedHealthcare may, however, in its discretion, pay a Non-Participating Provider directly for services rendered to Members. In the case of any such assignment of benefits or payment to a Non-Participating Provider, UnitedHealthcare reserves the right to offset benefits to be paid to the Non-Participating Provider by any amounts that the Non-Participating Provider owes UnitedHealthcare.

When a Member assigns benefits under this Contract to a Non-Participating Provider with UnitedHealthcare's consent, and the Non-Participating Provider submits a claim for payment, the Member and the Non-Participating Provider represent and warrant the following:

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

Depending on the geographic area and the service received, the member may have access [through our Shared Savings Program](#) to Non-Participating Providers who have agreed to discount their charges for Covered Services. If Covered Services are received from these providers, the Coinsurance percentage will remain the same as it is when Covered Services are received from Non-Participating Providers who have not agreed to discount their charges; however, the total amount owed may be less [when Covered Services are received from Shared Savings Program providers than from other Non-Participating Providers](#) because the Allowed Charge may be a lesser amount.

ARTICLE 12 - PREMIUMS

- 12.1 Only Members for whom the Group has paid the Premium shall be entitled to benefits for the period for which such payment has been received. UnitedHealthcare will allow Group a grace period of 31 days following the Premium due date. This Contract shall stay in force during the grace period. If payment is not received before the end of the grace period, coverage will be terminated at the end of the grace period with prior notice to Group but without prior notice from UnitedHealthcare to Members, and Group and/or Members will be held liable for benefits received during the grace period.
- [12.2 The Group or its delegate is the plan administrator under federal law including, but not limited to, the Employee Retirement Income Security Act (ERISA) and is responsible for various duties as plan administrator including, but not limited to, notice to Members of suspension or termination of coverage and reporting and disclosure requirements. UnitedHealthcare is not the plan administrator. The Group, or its delegate, but not UnitedHealthcare, is responsible for complying with the health care continuation provisions in the Consolidated Omnibus Budget Reconciliation Act of 1975 (COBRA), as amended, or any applicable state law.]
- [12.2 The Group or its delegate is the plan administrator under federal law and is responsible for various duties as plan administrator including, but not limited to, notice to Members of suspension or termination of coverage and reporting and disclosure requirements. UnitedHealthcare is not the plan administrator. The Group, or its delegate, but not UnitedHealthcare, is responsible for complying with the health care continuation provisions in the Consolidated Omnibus Budget Reconciliation Act of 1975 (COBRA), as amended, or any applicable state law.]

ARTICLE 13 - TERMINATION

- 13.1 In addition to termination for non-payment of Premium as explained in section 12.1, UnitedHealthcare may terminate this Contract at any time for one or more of the following reasons:
- 13.1.1 Death of the Subscriber: Upon the death of the Subscriber this Contract shall automatically terminate. For coverage rights, if any, of surviving Eligible Dependents, see Article 14 and Article 15.
- 13.1.2 Subscriber no longer eligible: If the Subscriber is no longer eligible to participate in the health benefits plan offered by the Group under this Contract, this Contract shall automatically terminate. For coverage rights, if any, of Subscriber and Eligible Dependents, see Article 14 and Article 15.
- 13.1.3 Fraud or misrepresentation of a material fact in enrolling or making claim for benefits under this Contract: Under such circumstances, UnitedHealthcare shall have the right to recover the full amount of any benefits paid on behalf of the Member.
- 13.1.4 Unauthorized use of a Member's UnitedHealthcare identification card by any other persons: Under such circumstances, UnitedHealthcare may retain the identification card and all rights of such Member and, if such Member is a Subscriber, all rights of his or her Eligible Dependents shall terminate.
- 13.1.5 Change in status as Eligible Dependent: If a Member is no longer within the definition of an Eligible Dependent, his or her benefits shall terminate. For coverage rights, if any, see Article 14 and Article 15.
- [13.1.6 Failure on the Member's part to pay Copayments, Coinsurance, Deductibles, or Penalty amounts.]
- [13.1.6 Failure on the Member's part to pay Copayments, Coinsurance, and/or Deductibles.]
- 13.1.7 Member engages in activities which endanger the safety and welfare of UnitedHealthcare or its employees or providers.

- 13.1.8 Expiration of the maximum continuation of coverage period as described in Article 14.
- 13.1.9 Such other reasons as may be approved by the appropriate regulatory agencies of the state of operation.
- 13.2 If the Group Health Contract which covers the Member terminates, this Contract shall terminate at the same time. If required by law, UnitedHealthcare shall give Member written notice prior to termination.
- 13.3 Upon termination of enrollment as provided in this Article or Article 12, Member shall cease to be entitled to any benefits under this Contract. However, if Member remains as an inpatient in a Hospital, Skilled Nursing Facility, or inpatient rehabilitation facility at the time of such termination, Member shall be entitled to an extension of benefits, subject to the terms and conditions of this Contract, for the treatment of the condition that has caused the confinement. Such an extension of benefits for Hospital, Skilled Nursing Facility, or inpatient rehabilitation facility services shall cease with the earliest occurrence of one of the following events:
 - 13.3.1 The date the Member is discharged from the Hospital, Skilled Nursing Facility, or inpatient rehabilitation facility;
 - 13.3.2 The date the Member reaches any Maximum Policy Benefit that applies.
 - 13.3.3 The date the Attending Physician determines that the inpatient stay is no longer necessary or appropriate.
 - 13.3.4 The date the Member becomes covered under another group health plan;
- 13.4 Except as provided in this Article, UnitedHealthcare must renew this Contract at the option of the Group, unless:
 - 13.4.1 The Group fails to pay Premiums or contributions in accordance with the terms of this Contract.
 - 13.4.2 The Group performs an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact under the terms of the coverage or, with respect to coverage of a Member, fraud, or intentional misrepresentation by the Member or the Member's representative. If the fraud or intentional misrepresentation is made by a person with respect to any person's prior health condition, UnitedHealthcare has the right to deny coverage to that person or to impose as a condition of continued coverage the exclusion of the condition misrepresented.
 - 13.4.3 The Group violates participation or contribution rules.
 - 13.4.4 UnitedHealthcare ceases to offer a particular type of health insurance coverage in such market in accordance with applicable state law. If UnitedHealthcare decides to discontinue such product that has been purchased by the Group, UnitedHealthcare will meet the following requirements:
 - 13.4.4.1 Provide written notice to Group and each Subscriber covered under this Contract, of the discontinuation of such product at least 90 days before the discontinuation of coverage;
 - 13.4.4.2 Offer to Group the option on a guaranteed basis to purchase any other health insurance coverage currently being offered by UnitedHealthcare in such market; and
 - 13.4.4.3 In exercising the option to discontinue such product and in offering the option of coverage under section 13.4.5, UnitedHealthcare will act uniformly without regard to claims experience of those Groups or any health status-related factor relating to any Members who may become eligible for such coverage.

- 13.4.5 UnitedHealthcare elects to discontinue offering all health insurance coverage in the State of Arkansas. Health insurance coverage may be discontinued by UnitedHealthcare only in accordance with applicable state law and if:
- 13.4.5.1 UnitedHealthcare provides written notice to the applicable state authority and to Group, at least 180 days prior to the discontinuation of coverage; and
 - 13.4.5.2 All affected group health contracts issued or delivered for issuance in the State of Arkansas are discontinued and coverage is not renewed.
- 13.5 A certificate of creditable coverage will be provided in accordance with state and federal law. Also, a Member may request a certificate of creditable coverage by contacting UnitedHealthcare at the appropriate address or toll-free telephone number listed in Attachment C.
- 13.6 **Extended Coverage if the Member is Hospitalized.** This provision is applicable only if the Group policy terminates and is replaced by a group health insurance policy or contract issued by another insurer or by a self-funded health care plan. However, the extension of coverage does not apply if termination of the Group policy occurs due to non-payment of Premium or fraud.
- If the Member is inpatient in a Hospital or other inpatient facility on the date coverage under the Group policy would otherwise terminate as described in the paragraph above, coverage will be extended until the earlier of:
- The date the Member's inpatient stay ends, or
 - The date the Member has exhausted the inpatient stay benefits under the Group policy.

ARTICLE 14 - CONTINUATION OF COVERAGE

- 14.1 **Continuation Coverage Under Federal Law.** If benefits under this Contract terminate due to a loss of eligibility according to the eligibility requirements established by UnitedHealthcare, continuation of coverage shall be provided if required under the terms and conditions of any applicable federal laws. Members should contact their Group's plan administrator to determine whether they are eligible to continue coverage under federal law.
- 14.2 **Continuation Coverage Under State Law.** In the event that a Member does not qualify for continuation of coverage under federal law, or if the Member does not elect coverage under federal law, the state of Arkansas requires that the following continuation coverage be available:
- 14.2.1 If a Member ceases to be covered under this Contract for any reason other than the termination of the Group policy in its entirety or the termination of an insured class of which the Member was a member, the Member shall be entitled to continue coverage at the same level of Group benefits for the remainder of the month in which termination occurred, plus an additional four months following the month of termination.
 - 14.2.1.1 To qualify for continuation, the Member must have been continuously covered under the Group policy (and under any group policy providing similar benefits which it replaces) for at least three months immediately prior to termination of employment membership or change in marital status. The Member is required to make advance payment of the full Group Premium for continuation to the Group on or before the beginning of each month's coverage.
 - 14.2.1.2 At the end of this period of continuation, the Member shall be entitled to have issued a policy of conversion coverage as described in Article XV.

- 14.2.1.3 Continuation coverage will end on the earliest of the following dates:
- 120 days from the date the continuation began.
 - The date coverage ends for failure to make timely payment of the Premium.
 - The date coverage ends because the Member violates a material condition of the Group Policy.
 - The date coverage is or could be obtained under any other group health plan.
 - The date the Group policy ends.

14.2.2 Member shall not be entitled to state continuation coverage if the Member's termination under the Group policy occurred because:

14.2.2.1 the Member failed to pay any required Premium or contribution;

14.2.2.2 the Member is eligible for Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded);
or

14.2.2.3 any discontinued Group coverage was replaced by similar group coverage within 31 days.

The continuation provisions in section 14.2 also apply to Eligible Dependents who are terminated from the Group's coverage because of divorce or the death of the Subscriber. If an Eligible Dependent becomes eligible for continuation under these conditions, he or she shall be entitled to have coverage continued for the remainder of the month in which termination occurred plus up to four additional months. Payment in full for this continuation coverage must be made in advance to the Group on or before the beginning of each month's coverage. Members whose Group coverage is terminated during pregnancy shall be entitled to have their coverage continued under the Group policy for the remainder of the month in which termination occurred plus a period of not less than six months after the pregnancy ends and not more than the end of the second three-month period following the three-month period in which the pregnancy ends.

This state mandated continuation privilege substitutes for a portion of the rights a Member may have under the Consolidated Omnibus Budget Reconciliation Act (COBRA). In the event the Member selects the state continuation privilege and, upon expiration, subsequently enrolls for coverage under COBRA, any time period that the Member spent enrolled under this state continuation provision shall be subtracted from the maximum time period required under COBRA.

Notification Requirements and Election Period for Continuation Coverage under State Law: The Group will provide Members with written notification of the right to continuation coverage when coverage ends under the Group policy. Members must elect continuation coverage after receiving this notification. Members should obtain an election form from the Group or the employer and, once election is made, forward all monthly Premiums to the Group for payment to UnitedHealthcare.

ARTICLE 15 - CONVERSION PRIVILEGE

- 15.1 If a Member ceases to be covered under this Contract for any reason other than those described in section 15.2.1, the Member is entitled to have issued to him or her, without evidence of insurability, an individual or family conversion policy. UnitedHealthcare may require Copayments, Coinsurance or Deductibles under the conversion policy that are different than those under the Group policy. Information regarding conversion coverage options will be provided by the local UnitedHealthcare office at the request of the Enrollee. Written application for a conversion policy must be made and the first premium paid to UnitedHealthcare within 31 days after the loss of Group coverage. The effective date of the conversion policy shall be the day following the termination of coverage under the Group policy.
- 15.2 A conversion policy shall not be made available to a Member whose coverage terminates under the Group policy if:

- 15.2.1 Member's termination under the Group policy occurred because:
 - 15.2.1.1 the Member failed to pay any required Premium or contribution;
 - 15.2.1.2 the Member is eligible for Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965, or as later amended or superseded); or
 - 15.2.1.3 any discontinued Group coverage was replaced by similar group coverage within 31 days.
 - 15.2.2 Member is covered by or eligible for Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965, or as later amended or superseded);
 - 15.2.3 Member is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical services subscriber contract or medical practice or other prepayment plan or by any other plan or program;
 - 15.2.4 Member is covered by or eligible for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis;
 - 15.2.5 Member is covered by or eligible for similar benefits, pursuant to or in accordance with the requirements of any state or federal law; or
 - 15.2.6 The benefit provided under section 15.2.3 or benefits provided or available under sections 15.2.4 and 15.2.5, together with the benefits provided by the conversion policy, would result in overinsurance according to UnitedHealthcare's standards.
- 15.3 Effective date of the conversion contract will be on the date of termination from the Group Health Contract.

ARTICLE 16 - REINSTATEMENT AND MISCELLANEOUS PROVISIONS

- 16.1 Any Contract which is terminated in any manner as provided herein may be reinstated by UnitedHealthcare at its sole discretion.
- 16.2 This Contract is personal to the Member and shall not be assigned, delegated, or transferred.
- 16.3 Applicants for enrollment shall complete and submit to UnitedHealthcare such applications, medical review questionnaires, or other forms or statements as UnitedHealthcare may reasonably request. Applicants agree that all information contained in such materials shall be true, correct and complete to the best of their knowledge and belief.
- 16.4 Members may request additional identification cards, free of charge, by contacting UnitedHealthcare at the toll-free telephone number listed in Attachment C. Any cards issued by UnitedHealthcare to Members pursuant to this Contract are for identification only. Possession of a UnitedHealthcare identification card confers no right to services or other benefits under this Contract. To be entitled to such services or benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable charges under this Contract have actually been paid. Any person receiving services or other benefits to which he or she is not entitled pursuant to the provisions of this Contract shall be charged at prevailing rates.
- 16.5 UnitedHealthcare may receive rebates from pharmaceutical manufacturers. Rebates are the exclusive property of UnitedHealthcare and will not be considered when determining a Member's cost-sharing obligations, such as any applicable Copayment, Coinsurance, or Deductible.

- 16.6 UnitedHealthcare may adopt reasonable policies, procedures, rules and interpretations to promote orderly and efficient administration of this Contract.
- 16.7 **Entire Contract; Changes.**
- 16.7.1 This Contract constitutes the entire Contract between the parties and, as of the effective date hereof, supersedes all other agreements, oral or otherwise, between the parties regarding the subject matter of this Contract and may not be altered or amended except in writing.
- 16.7.2 No agent or other person, except an officer of UnitedHealthcare, has authority to waive any conditions or restrictions of this Contract; to extend the time for making a payment; or to bind UnitedHealthcare by making any promise or representation or by giving or receiving any information. No change in this Contract shall be valid unless evidenced by an endorsement on it signed by one of the aforesaid officers, or by an amendment to it signed by the Group and by one of the aforesaid officers, and filed with the appropriate regulatory agencies of the state of operation.
- 16.8 By electing coverage pursuant to this Contract, or accepting benefits under this Contract, all Members and their applicable legal representatives expressly agree to all terms, conditions and provisions of this Contract.
- 16.9 **Legal Actions.** No civil action shall be brought to recover on this Contract prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Contract. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

ARTICLE 17 - MEMBER COMPLAINT, APPEAL, AND DISPUTE RESOLUTION PROCEDURES

- 17.1 This Article sets forth a formal system for resolving Complaints and Appeals by Members concerning coverage determinations, the provision of health care services or other matters concerning the operation of UnitedHealthcare.
- 17.2 The following definitions apply to this Article 17:
- 17.2.1 “Appeal” means a Complaint, which having been reported to UnitedHealthcare by the Member and remaining unresolved to the Member’s satisfaction, is filed for formal proceedings as set forth in this Article 17.
- 17.2.2 “Authorized Representative” means the Member’s guardian or an individual the Member has authorized to act on his or her behalf, including but not limited to the Member’s Physician.
- 17.2.3 “Complaint” means an oral or written expression of dissatisfaction relating to the policies of or the services provided by UnitedHealthcare.
- 17.2.4 “Post-Service Claim” means any claim for a benefit that is not a Pre-Service Claim.
- 17.2.5 “Pre-Service Claim” means any claim for a benefit with respect to which the terms of the Contract condition receipt of the benefit, in whole or part, based on approval of the benefit in advance of obtaining medical care.
- 17.2.6 “Urgent Care Claim” means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (a) could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or (b) in the opinion of a Physician with knowledge of the Member’s medical condition, would subject the Member to severe

pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

17.3 Most Complaints can be resolved satisfactorily on an informal basis by consultation between the Member, UnitedHealthcare staff, and/or the health care practitioner from whom the Member has received services. If a Member's Complaint is not resolved through informal consultation, the Member or Member's Authorized Representative may request a formal Appeal. If the Member wants to designate an Authorized Representative to assist him or her with the Appeal, this must be done in writing. A Member's Authorized Representative may not file a formal Appeal without explicit, written designation by the Member.

17.4 **Expedited Appeal Procedure for Urgent Care Claims.** For Urgent Care Claims, the Member or Member's Authorized Representative may contact UnitedHealthcare, orally or in writing, to request expedited consideration of the Member's formal Appeal.

17.4.1 In determining whether a claim is for urgent care, UnitedHealthcare will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If the request for expedited consideration is denied by UnitedHealthcare, the Member's or Member's Authorized Representative's Appeal will automatically be reviewed by UnitedHealthcare according to the Appeal Procedure provided in section 17.5. The request for expedited consideration will not be denied if a Physician with knowledge of the Member's medical condition determines that a claim involves urgent care. The appeal process for urgent situations does not apply to pre-scheduled treatments, therapies or surgeries.

17.4.2 Within 72 hours after UnitedHealthcare receives a request for expedited handling which includes all necessary information, UnitedHealthcare will issue a decision to the member or their Authorized Representative by telephone or facsimile.

17.4.3 Written confirmation of UnitedHealthcare's final decision will be mailed to the member or thier Authorized Representative within three calendar days after UnitedHealthcare provides the final decision by telephone or facsimile

17.4.4 If the Member or Member's Authorized Representative is not satisfied with the decision described in section 17.4.2, he or she may request an External Independent Review (EIR) as provided in section 17.6. External review is not available if coverage decision is based on benefit exclusions or defined benefit limits.

17.5 **Appeal Procedure for Pre-Service and Post-Service Claims that are not Urgent Care Claims.** For Pre-Service and Post-Service Claims that are not Urgent Care Claims, the Member or Member's Authorized Representative may request an Appeal by completing a written "Appeal Form," which shall be provided by UnitedHealthcare upon the written or oral request of the Member or Member's Authorized Representative. The Appeal Form must be completed and filed to UnitedHealthcare within 180 days from the date (a) the Member received notification of a denial of coverage or (b) the problem in question occurred. The Appeal Form shall be completed and signed and the facts as alleged shall be binding on Member. The Appeal Form shall be filed by mail, facsimile, or hand-delivery to UnitedHealthcare, in accordance with instructions provided with the Appeal Form.

17.5.1 For determinations as to whether a specific service, procedure, or treatment is [medically necessary (described in section 4.3)] [a Covered Service] or for any other determination requiring medical judgment, UnitedHealthcare shall issue a decision, in writing, to all parties involved within the following timeframes:

Pre-Service Claim: 30 calendar days after receipt of Appeal Form.

Post-Service Claim: 60 calendar days after receipt of Appeal Form.

If the Member or Member's Authorized Representative is not satisfied with the decision described in this section 17.5.1, the Member or Member's Authorized Representative may request an External Independent

Review (EIR) as provided in section 17.6

17.5.2 For all other Appeals that are not Urgent Care Claims, UnitedHealthcare shall issue a decision, in writing, to all parties involved within the following timeframes:

Pre-Service Claim: 30 calendar days after receipt of Appeal Form.

Post-Service Claim: 60 calendar days after receipt of Appeal Form.

If the Member or Member's Authorized Representative is not satisfied with the decision described in this section 17.5.2, the Member or Member's Authorized Representative may request a reconsideration of the Appeal decision, as provided in section 17.7.

17.6 **External Independent Review.** A Member, Member's Authorized Representative, or the Attending Physician acting on behalf of Member, may request External Independent Review (EIR) of an adverse decision resulting from an Appeal described in section 17.4 or section 17.5.1. These provisions for EIR are not to be construed to require payment for any health care treatment or service which is not covered under Member's Contract.

17.6.1 Member, or the Attending Physician acting on behalf of Member, may file a request for external review by mailing to the address provided in Attachment C, a request in writing within 60 days of UnitedHealthcare's final adverse decision in section 17.4 or section 17.5.1 described in the letter from UnitedHealthcare conveying that decision. Except in the case of an expedited review, the Member will pay a filing fee of \$25 which must accompany the request for EIR, but such filing fee may be waived by the Insurance Commissioner upon a showing of undue financial hardship. The filing fee will be refunded if the EIR decision is in favor of Member.

17.6.2 UnitedHealthcare will provide to the approved independent review entity copies of all information UnitedHealthcare received and any documents relevant to UnitedHealthcare's final adverse decision described in section 17.4.2 or section 17.5.1.

Within 5 business days after receipt of the request for external review, the independent review entity will complete the preliminary review and notify the health plan if request is complete and the request has been accepted for external review. Additional information may be submitted to the independent review entity within 7 business days following the date of receipt of the independent review entity notice. If not complete the assigned independent review entity will inform of the reasons for its non-acceptance.

17.6.3 The standard of review to be used by an independent review entity shall be whether the health care service or treatment denied by UnitedHealthcare was [medically necessary] [a Covered Service] as defined by this Contract and consistent with clinical standards of medical practice. The independent review entity shall submit its decision as soon as possible but not more than 45 calendar days from its receipt of all necessary information.

17.6.4 An expedited EIR shall be conducted if Member's Attending Physician states that delay would pose an imminent or serious threat to Member's health. UnitedHealthcare will select an approved independent review entity to conduct the expedited EIR within 72 hours. Expedited external review is not provided for post service claims.

17.6.5 The EIR decision is binding upon UnitedHealthcare. UnitedHealthcare shall pay all reasonable fees and costs of the independent review entity in conducting the EIR.

17.7 **Member Reconsideration Procedure.** The Member or Member's Authorized Representative shall have 30 days from the date the Appeal decision was issued pursuant to section 17.5.2, in which to file a request for reconsideration to the Member Reconsideration Committee of UnitedHealthcare. The Committee meeting

shall be held at the UnitedHealthcare home office in Moline, Illinois. Member or Member's Authorized Representative will be notified that the Member Reconsideration Committee will meet to hear his or her case and Member or Member's Authorized Representative will be provided the opportunity to submit additional information and comments in writing. The Member Reconsideration Committee shall resolve the Appeal by majority vote and shall issue a final written decision to all parties involved within the following timeframes:

Pre-Service Claim: 15 calendar days after receipt of the request for reconsideration.

Post-Service Claim: 30 calendar days after receipt of the request for reconsideration.

- [17.8] After exhausting the Appeal procedure of section 17.4 or section 17.5.1 or the reconsideration procedure of section 17.7, as applicable, if the Member remains dissatisfied, he or she may bring a civil action under section 502(a) of the Employee Retirement Security Income Act (ERISA).]
- [17.9] Upon written request and free of charge, the Member or Member's Authorized Representative may request copies of all documents relevant to an Appeal or reconsideration.
- [17.10] For further information about any procedure in this Article 17, the Member may contact either UnitedHealthcare or the Arkansas Insurance Commissioner at the addresses or toll-free telephone numbers provided in Attachment C.

ARTICLE 18 - NOTICE

- 18.1 Any notice given by UnitedHealthcare to the Member shall be sufficient if mailed to the Member at his or her address as it appears on the records of UnitedHealthcare. It is the Member's responsibility to notify the personnel department of his or her Group of any and all changes in address. Any notice shall be deemed delivered when deposited in the United States mail at any post office or postal box with first class postage prepaid.

ARTICLE 19 - RIGHT OF SUBROGRATION AND REIMBURSEMENT

- 19.1 **Subrogation.** In the event of any payment of benefits for which a Member may have a claim or cause of action against any person or organization, UnitedHealthcare shall be subrogated to all right of recovery of the Member with respect to any judgment, payment or settlement for personal injury. The Member agrees as follows:
 - 19.1.1 To fully cooperate with UnitedHealthcare in obtaining information about the loss and its cause;
 - 19.1.2 To notify UnitedHealthcare of any claim for damages made or lawsuit filed on behalf of the Member in connection with the loss;
 - 19.1.3 To include the amount of the benefits paid by UnitedHealthcare on behalf of the Member in claims for damages against other parties;
 - 19.1.4 To notify UnitedHealthcare of a proposed settlement at least 30 days before any claim or lawsuit is settled in regard to the loss;
 - 19.1.5 To provide UnitedHealthcare with a lien, to the extent of the cash value of these services and supplies provided. Such lien may be filed with the person whose act caused the injuries, his or her agent or a court having jurisdiction in the matter;

19.1.6 To pay UnitedHealthcare all costs and expenses, including attorney's fees, which were incurred or expended by UnitedHealthcare in obtaining or attempting to obtain payment from Member if he or she fails or refuses to reimburse UnitedHealthcare pursuant to this provision; and

19.1.7 To permit UnitedHealthcare to file a lawsuit in the name of the Member against the person whose act caused the injuries.

19.2 **Right of Reimbursement.** If a Member incurs expenses for sickness or injury that occurred due to the negligence of a third party: (a) UnitedHealthcare has the right to reimbursement for all benefits UnitedHealthcare paid from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Member, Member's parents, if the Member is a minor, or Member's legal representative as a result of that sickness or injury; and (b) UnitedHealthcare is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits UnitedHealthcare paid for that sickness or injury.

19.2.1 If UnitedHealthcare is the primary plan, UnitedHealthcare shall have the right to first reimbursement out of all funds the Member, the Member's parents, if the Member is a minor, or the Member's legal representative, is or was able to obtain for the same expenses UnitedHealthcare has paid as a result of that sickness or injury.

19.2.2 Member is required to furnish any information or assistance or provide any documents that UnitedHealthcare may reasonably require in order to obtain its rights under this provision. This provision applies whether or not the third party admits liability.

ARTICLE 20 - COORDINATION OF BENEFITS

Coordination of Benefits with This Plan and Other Coverage

20.1 **Applicability.**

[20.1.1 This Coordination of Benefits (COB) provision does not apply to any supplemental benefits rider for prescription drugs under This Plan.]

20.1.2 This Coordination of Benefits (COB) provision applies to This Plan when a Member has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

20.1.3 If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

20.1.3.1 shall not be coordinated when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but

20.1.3.2 may be coordinated when, under the order of benefit determination rules, another Plan determines its benefits first. The above coordination is described in section 20.4, Effects on the Benefits of This Plan.

20.2 **Definitions.**

20.2.1 "Plan" is any of these which provide benefits or services for, or because of, medical or dental care or treatment:

20.2.1.1 Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

20.2.1.2 Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other nongovernmental program.

Each contract or other arrangement for coverage under section 20.2.1.1 or 20.2.1.2 is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

20.2.2 "This Plan" is the part of the Group Health Contract that provides benefits for health care expenses.

20.2.3 "Primary Plan"/"Secondary Plan". The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be coordinated because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

20.2.4 "Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, subject to the terms and conditions of this Contract, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. This Plan shall not have payment liability as secondary carrier for charges not covered under this Contract unless the Member has established a credit within the Coordination of Benefits reserve bank.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

20.2.5 "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

20.3 **Order of Benefit Determination Rules.**

20.3.1 **General.** When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

20.3.1.1 the other Plan has rules coordinating its benefits with those of This Plan; and

20.3.1.2 both those rules and This Plan's rules, in section 20.3.2 below, require that This Plan's benefits be determined before those of the other Plan.

20.3.2 **Rules.** This Plan determines its order of benefits using the first of the following rules which applies:

20.3.2.1 Non-dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or Subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent.

20.3.2.2 Dependent Child/Parents Not Separated or Divorced. Except as stated in section 20.3.2.3 below, when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

20.3.2.2.1 the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year, but

20.3.2.2.2 if both parents have the same birthday, the benefits of the Plan which has covered the parent longer are determined before those of the Plan which has covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in section 20.3.2.2.1 above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

20.3.2.3 Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

20.3.2.3.1 first, the Plan of the parent with custody of the child;

20.3.2.3.2 then, the Plan of the spouse of the parent with the custody of the child, and

20.3.2.3.3 finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of the parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

20.3.2.4 Active/Inactive Employees. The benefits of the Plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule 20.3.2.4 is ignored.

20.3.2.5 Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or Subscriber longer are determined before those of the Plan which covered that person for the shorter time.

20.4 **Effects on the Benefits of This Plan.**

20.4.1 **When This Section Applies.** This section 20.4 applies when, in accordance with section 20.3, Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be coordinated under this section. Such other Plan or Plans are referred to as "the other Plans" in 20.4.2 below.

20.4.2 **Coordination in this Plan's Benefits.** The benefits of This Plan will be coordinated when the sum of:

20.4.2.1 the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

20.4.2.2 the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be coordinated so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are coordinated as described above, each benefit is coordinated in proportion. It is then charged against any applicable benefit limit of This Plan.

20.5 **Right to Receive and Release Needed Information.** Certain facts are needed to apply these COB rules. UnitedHealthcare has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. UnitedHealthcare need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts it needs to pay the claim.

20.6 **Facility of Payment.** A payment under another Plan may include an amount which should have been paid under this Plan. If it does, UnitedHealthcare may pay the amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. UnitedHealthcare will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

20.7 **Right of Recovery.** If the amount of the payments made by UnitedHealthcare is more than it should have paid under this COB provision, it may recover the excess from one or more of:

20.7.1 the persons it has paid or for whom it has paid;

20.7.2 insurance companies; or

20.7.3 other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

20.8 **Worker's Compensation/Government Programs.** The order of primary responsibility stated above shall not apply when the Member is entitled to receive health care services or indemnity benefits (a) under Worker's Compensation or similar law, or (b) in a Hospital or facility owned or operated by any government agency. In such case, the primary responsibility shall rest with those persons or agencies having the obligation to provide the health care services or indemnity benefits under (a) or (b) above.

ARTICLE 21 - DISCRETIONARY AUTHORITY OF UNITEDHEALTHCARE

21.1 UnitedHealthcare has discretionary authority to determine eligibility for benefits and to construe and interpret all terms and provisions of this Contract and may delegate its discretionary authority to another person, partnership, corporation or other legal entity.

UnitedHealthcare Insurance Company of the River Valley
[Attachment D -]Schedule of Benefits

Please refer to your Provider Directory for listings of Participating Physicians, Hospitals, and other Providers.

Deductibles and Maximums	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
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Deductible [(calendar year)] [(Contract Period)]

[[Individual] [Self Only]	[\$100-\$10,000] [Not applicable] [for self only coverage]	[\$200-\$20,000] [for self only coverage]
[Family] [Self and Family]	[\$100-\$20,000] [for family coverage] [Not applicable]	[\$200-\$40,000] [for family coverage]

(The In-Network Deductible and Out-of-Network Deductible are separate.)

[Once the family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the [calendar year] [Contract Period].] [All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.]

{OR}

[[Individual] [Self Only]	[\$100-\$20,000] [Not applicable] [for self only coverage]
[Family] [Self and Family]	[\$100-\$40,000] [for family coverage] [Not applicable]

(The In-Network Deductible and Out-of-Network Deductible are combined.)

[Once the family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the [calendar year] [Contract Period].] [All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.]

Maximum Out-of-Pocket Expense [(calendar year)] [(Contract Period)] [(includes [Copayments] [,][and][Coinsurance] [,] [and] [Deductibles])]

[Individual] [Self Only]	[\$100-\$20,000] [for self only coverage] [Not applicable]	[\$200-\$40,000] [for self only coverage] [Not applicable]
[Family] [Self and Family]	[\$100-\$40,000] [for family coverage] [Not applicable]	[\$200-\$80,000] [for family coverage] [Not applicable]

(The In-Network Maximum Out-of-Pocket Expense and Out-of-Network Maximum Out-of-Pocket Expense are separate.) [All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.] [Member Copayments do not accumulate to the Out-of-Pocket Maximum.]

{OR}

[Individual] [Self Only]	[\$100-\$40,000] [for self only coverage] [Not applicable]
[Family] [Self and Family]	[\$200-\$80,000] [for family coverage] [Not applicable]

(The In-Network Maximum Out-of-Pocket Expense and Out-of-Network Maximum Out-of-Pocket Expense are combined.) [All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.] [Member Copayments do not accumulate to the Out-of-Pocket Maximum.]

Maximum Policy Benefit per Member	[None] [\$1,000,000-\$10,000,000]	[None] [\$1,000,000-\$10,000,000]
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[(Plan pays a maximum benefit which is separate for In-Network and Out-of-Network.)]

{OR}

Maximum Policy Benefit per Member	[None] [\$1,000,000-\$10,000,000]
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[(Plan pays a maximum benefit which includes both In-Network and Out-of-Network.)]

[4th Quarter Deductible Carryover	[Applicable] [Not Applicable]	[Applicable] [Not Applicable]
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{OR}

[Applicable] [Not Applicable]

Benefits for Covered Services	Participating Provider In-Network Member Pays	Non-Participating Provider (1) Out-of-Network Member Pays
Preventive Care Services		
<i>("Preventive Care" refers to examinations and services recommended by the U.S. Preventive Services Task Force or preventive care services mandated by state or federal law or regulation.)</i>		
Physical Exams/Well-Child Care	[[0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply] [Not Covered]
Immunizations	Charge paid at 100% for children newborn through 18 years of age For members over the age of 18, [[0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply].	Charge paid at 100% for children newborn through 18 years of age. . For members over the age of 18, [0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply] [Not Covered].
Laboratory and X-ray	[[0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-50%] of Allowed Charge [after Deductible] [for children newborn through 6 years of age.] [Services not covered for children age 7 years and up.] [Deductible does not apply] [Not Covered]
Physician Office Services		
Office Visits	[[0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply.]
Office Surgery	[[0-\$500] Copayment per surgery] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply.]
Allergy Testing	[[0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply.] [Not covered]
Allergy Injections	[[0-\$100] Copayment per injection] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply.] [Not covered]
Other Injections	[[0-\$100] Copayment per injection] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply.]
Maternity Physician Services	[[0-\$600] Copayment per pregnancy] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply.]
Newborn Physician Services		
Inpatient	<i>See "Physician Services at a Facility other than the Office" and "Facility Services."</i>	
Outpatient	<i>See "Physician Office Services."</i>	

Benefits for Covered Services	Participating Provider In-Network Member Pays	Non-Participating Provider (1) Out-of-Network Member Pays
Physician Services at a Facility other than the Office		
Home Visits	[[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply]
Inpatient Facility Visits	[[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply]
Outpatient Facility Visits	[[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply]
Inpatient Surgery	[[[\$0-\$1,000] Copayment per surgery] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply]
Outpatient Surgery	[[[\$0-\$1,000] Copayment per surgery] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply]
[Morbid Obesity Surgery (2)]	<i>[See “Physician Office Services,” “Physician Services at a Facility other than the Office,” and “Facility Services.”]</i>	
[Any combination of In-Network and Out-of-Network Benefits are limited to a \$[50,000 – 250,000] maximum policy benefit per member.]		
Emergency Services		
<i>[(Follow-up care obtained in the emergency room is not covered.)]</i>		
Emergency Room Physician	[[[\$0-\$100] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[[\$0-\$100] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
Emergency Room	[[[\$0-\$500] Copayment per visit for a Medical Emergency.] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge for a Medical Emergency] [after Deductible] [Deductible does not apply] [Emergency Room Copayment waived if admitted.] [Physician’s services or other services separately charged may require a separate Copayment and/or Coinsurance in addition to any applicable Deductible, beyond the emergency room facility charge.] [Services must be obtained from a Participating Provider.]	[[[\$0-\$500] Copayment per visit for a Medical Emergency.] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge for a Medical Emergency] [after Deductible] [Deductible does not apply] [Emergency Room Copayment waived if admitted.] [Physician’s services or other services separately charged may require a separate Copayment and/or Coinsurance in addition to any applicable Deductible, beyond the emergency room facility charge.] [Services must be obtained from a Participating Provider.]

Benefits for Covered Services	Participating Provider In-Network Member Pays	Non-Participating Provider (1) Out-of-Network Member Pays
Urgent Care Facility	[[[\$0-\$250] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply.]
Ambulance Services	[[[\$35-\$250] Copayment] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge][in a Medical Emergency] [after Deductible] [Deductible does not apply] [Non-emergency transports must be approved in advance by UnitedHealthcare.]	[[[\$35-\$250] Copayment] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge][in a Medical Emergency] [after Deductible] [Deductible does not apply] [Non-emergency transports must be approved in advance by UnitedHealthcare.]
Laboratory and X-ray Services Outpatient	[[[\$0-\$100] Copayment] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
Office	[[[\$0-\$100] Copayment] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
[Note X-ray and laboratory services separately charged by an independent laboratory may require separate Coinsurance and/or Deductible, beyond the physician's office Copayment, Coinsurance and/or Deductible.]		
Chemotherapy, Radiation Therapy, Renal Dialysis Services Hospital (Outpatient)	[[[\$0-\$100] Copayment] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
Office	[[[\$0-\$100] Copayment] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
Facility Services		
Inpatient Facility [(2)]	[[[\$0-\$1,000] Copayment per [admission] [day] [up to a maximum of 5 continuous days] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
Outpatient Facility	[[[\$0-\$1,000] Copayment per day] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
Skilled Nursing Facility [(2)] - <i>[(Limited to [40-180] Skilled Nursing Facility days per [calendar year] [Contract Period])]</i> <i>[(The In-Network and Out-of-Network days are combined.)] [Must be approved in advance by UnitedHealthcare]</i>	[[[\$0-\$1,000] Copayment per [admission] [day] [up to a maximum of 5 continuous days] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
Medical Equipment		
<i>[(Diabetic supplies do not count toward the [Durable Medical Equipment] [and] [Prosthetic Device] benefit maximum.)]</i>		

Benefits for Covered Services	Participating Provider In-Network Member Pays	Non-Participating Provider (1) Out-of-Network Member Pays
Durable Medical Equipment [(2)] <i>[(Plan pays a maximum benefit of \$2,500-\$40,000] per [calendar year] [Contract Period] for Durable Medical Equipment which includes both In-Network and Out-of-Network.)]</i>	[[\$0-\$100] Copayment] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[\$0-\$100] Copayment] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Not covered]
Prosthetic Devices [(2)] <i>[(Plan pays a maximum benefit of \$2,500-\$40,000] per [calendar year] [Contract Period] for Prosthetic Devices which includes both In-Network and Out-of-Network.)]</i>	[[\$0-\$100] Copayment] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[\$0-\$100] Copayment] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Not covered]
Hearing Aid Devices <i>[(Plan pays a maximum benefit of \$2,500-\$5,000] per [calendar year] [Contract Period]</i>	[[\$0-\$100] Copayment] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[\$0-\$100] Copayment] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Not covered]
Foot Orthotics [(2)] <i>[(Limited to one pair custom molded shoe inserts once every [12] [24] months.)]</i>	[[\$0-\$100] Copayment] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[\$0-\$100] Copayment] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
Outpatient Rehabilitative Therapy <i>[(Limited to [60-120] visits per [calendar year] [Contract Period])] [(The In-Network and Out-of-Network visits are combined.)]</i> <i>Outpatient Rehabilitative Therapy includes physical, speech, and occupational therapy and cardiac (Phase I and II) and pulmonary rehabilitation.</i>	[[\$0-\$100] Copayment] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[\$0-\$100] Copayment] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
<i>Bracketed language will be used for non-HDHP plans</i>	[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply.]
[Spinal Manipulative Services]	<i>Bracketed language will be used for HDHP plans</i> [[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	
Home Health Services [(2)] <i>[(Limited to [60-120] visits per [calendar year] [Contract Period])] [(The In-Network and Out-of-Network visits are combined.)][Must be approved in advance by UnitedHealthcare]</i>	[[\$0-\$100] Copayment] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[\$0-\$100] Copayment] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Not covered]
Hospice Services [(2)]	[[\$5-\$100] Copayment per day] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
Respite Care [(2)] <i>[(Limited to [5-10] Respite Care days per [calendar year] [Contract Period])] [(The In-Network and Out-of-Network days are combined.)]</i>	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]

Benefits for Covered Services	Participating Provider In-Network Member Pays	Non-Participating Provider (1) Out-of-Network Member Pays
Organ and Tissue Transplants [(2)]	<i>Covered as any other medical condition. See “Physician Office Services,” “Physician Services at a Facility other than the Office,” and “Facility Services.”</i>	[Not covered] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
[Cornea Transplants]	<i>[Covered as any other medical condition. See “Physician Office Services,” “Physician Services at a Facility other than the Office,” and “Facility Services.”]</i>	
[Mental Health Services]		
[Inpatient Facility] [(2)]	[[\$0-\$1,000] Copayment per [admission] [day] [up to a maximum of 5 continuous days]] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
[Inpatient Physician Visits] [(2)]	[[\$0-\$75] [PCP]/[] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
[Outpatient Facility] [(2)]	[[\$0-\$1,000] Copayment per day] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
[Outpatient Physician Services] [(2)]	[[\$0-\$75] [PCP]/[] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
[Office Visits] [(2)]	[[\$0-\$75] [PCP]/[] [\$5-\$100] [Specialist] Copayment per visit] [Balance of allowed charge paid at 100%] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
[Substance Abuse Services]		
[Inpatient Facility] [(2)]	[[\$0-\$1,000] Copayment per [admission] [day] [up to a maximum of 5 continuous days]] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
[Inpatient Physician Visits] [(2)]	[[\$0-\$75] [PCP]/[] [\$5-\$100] [Specialist] Copayment per visit] [Balance of allowed charge paid at 100%] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
[Outpatient Facility] [(2)]	[[\$0-\$1,000] Copayment per visit] [Balance of allowed charge paid at 100%] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
[Outpatient Physician Services] [(2)]	[[\$0-\$75] [PCP]/[] [\$5-\$100] [Specialist] Copayment per visit] [Balance of allowed charge paid at 100%] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]

Benefits for Covered Services	Participating Provider In-Network Member Pays	Non-Participating Provider (1) Out-of-Network Member Pays
[Office Visits] [(2)]	[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [[0%-50%] of Allowed Charge] [after Deductible] [Balance of allowed charge paid at 100%] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
In vitro fertilization [(2)]	[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [[0%-50%] of Allowed Charge] [after Deductible] [Balance of allowed charge paid at 100%] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
[Any combination of In-Network and Out-of-Network Benefits are limited to a \$[15,000 – 50,000] maximum per Member per lifetime.]	[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [[0%-50%] of Allowed Charge] [after Deductible] [Balance of allowed charge paid at 100%] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
Medical Foods [(2)]	[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [[0%-50%] of Allowed Charge] [after Deductible] [Balance of allowed charge paid at 100%] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
[Musculoskeletal Disorders of the Face, Neck or Head] [(2)]	[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [[0%-50%] of Allowed Charge] [after Deductible] [Balance of allowed charge paid at 100%] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
Orthotic Devices and Services [(2)]	[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [[0%-50%] of Allowed Charge] [after Deductible] [Balance of allowed charge paid at 100%] [Deductible does not apply]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]

Coverage Limitations

- (1) For services from Non-Participating Providers, the Allowed Charge is the [Maximum Allowance] [Maximum Non-Network Reimbursement Program (MNRP)]. Except when services were rendered in a Medical Emergency, the Member is responsible for paying any amounts exceeding the [Maximum Allowance] [MNRP] for services received from Non-Participating Providers. Such excess amounts will not count toward the Deductible or Maximum Out-of-Pocket Expense.
- [(2) Services require Preauthorization. When a Member uses Participating Providers, the Participating Provider is responsible for obtaining Preauthorization. When a Member uses Non-Participating Providers, the Member is responsible for obtaining Preauthorization from UnitedHealthcare (or for mental health and substance abuse services, from UnitedHealthcare’s mental health and/or substance abuse treatment program provider). [If the Member fails to obtain Preauthorization for Covered Services from Non-Participating Providers, the Member will pay a Penalty of an additional 10 percentage points in his or her Out-of-Network Coinsurance.] [The Penalty amount paid by the Member will not exceed \$1,000, and it will not count toward the Deductible or Maximum Out-of-Pocket Expense.]

[NOTE: Treatment of a medical complication resulting from abuse of or addiction to alcohol or drugs shall not count toward any of the Substance Abuse maximums shown under this heading. Payment for medical complications will be as for any other illness.]

When multiple Covered Services are performed, the Copayment, Coinsurance, and/or Deductible applicable to each Covered Service will apply. For example, a laboratory and x-ray service separately charged by an independent laboratory outside of the Physician’s office has a separate Copayment, Coinsurance and/or Deductible in addition to the Physician’s office Copayment, Coinsurance or Deductible.

Definitions

Allowed Charge – the portion of a charge for a Covered Service that UnitedHealthcare will consider in calculating benefits. **For Covered Services received from a Participating Provider**, the Allowed Charge is the rate UnitedHealthcare has agreed to pay the Participating Provider under a contract. **For Covered Services received from a Non-Participating Provider due to a Medical Emergency**, the Allowed Charge is the [Maximum Allowance] [“In-Network” level of benefits, shown in Attachment D]. If the Billed Charge exceeds the [Maximum Allowance][“In-Network” level of benefits], the Member is not responsible for paying the Non-Participating Provider the difference between the Non-Participating Provider’s Billed Charge and the [Maximum Allowance][“In-Network” level of benefits]. **For non-**

emergency Covered Services received from a Non-Participating Provider, the Allowed Charge is [the Maximum Allowance][determined based on the maximum non-network reimbursement program (MNRP) rate set forth in the Certificate of Coverage]. If the Billed Charge exceeds the [Maximum Allowance][MNRP rate], the Member is responsible for paying the Non-Participating Provider the difference between the Non-Participating Provider's Billed Charge and the [Maximum Allowance][MNRP rate].

Copayment: The amount, if any, the Member must pay for each covered health service received, such as a doctor visit. The amount is specified per service. Each Copayment shall be paid at the time the service is provided.

Coinsurance: A percentage of the Allowed Charge that the Member must pay for Covered Services received.

Use this definition of Deductible with non-HDHP Plans and with embedded HDHP Plans:

[Deductible: The dollar amount, if any, the Member must pay for health services before benefits are payable under the Contract.]

Use this definition of Deductible with non-embedded HDHP Plans:

[Deductible: the amount the Member must pay for health services before UnitedHealthcare begins to pay, as shown for self-only or family coverage. Only those charges which would otherwise be payable by UnitedHealthcare in the absence of application of the Deductible shall count toward the Deductible. The Deductible amount for self-only coverage applies when the Subscriber alone is covered by the Contract; the Deductible amount for family coverage applies when the Subscriber and Eligible Dependents are covered by the Contract.]

[4th Quarter Deductible Carryover: Dollar amounts incurred by a Member during the last three months of a [calendar year][Contract Period], which were counted toward any applicable Deductible during that [calendar year][Contract Period] of a UnitedHealthcare benefit plan with a 4th Quarter Deductible Carryover provision, will also count toward any applicable Deductible for the following [calendar year][Contract Period].]

Maximum Policy Benefit: For benefit plans that have a Maximum Policy Benefit, this is the maximum amount that UnitedHealthcare will pay for benefits during the entire period of time that Members are enrolled under the Contract.

[Maximum Allowance: The portion of a Non-Participating Provider's charge which UnitedHealthcare will consider in calculating benefits. The Maximum Allowance will be determined based on UnitedHealthcare's determination of the average discount UnitedHealthcare has negotiated with Participating Providers for that service. If the Billed Charge exceeds the Maximum Allowance, the Member is responsible for paying the Non-Participating Provider the difference between the Non-Participating Provider's Billed Charge and the Maximum Allowance, except when services were rendered in a Medical Emergency. Any amount paid by a Member which is in excess of the Maximum Allowance for Covered Services shall not count toward any applicable Deductible or Maximum Out-of-Pocket Expense.]

Use this definition of Maximum Out-of-Pocket Expense with non-HDHP Plans and with embedded HDHP Plans:

[Maximum Out-of-Pocket Expense: The sum total amount of [Copayments, Coinsurance and Deductibles] [Coinsurance and Deductibles], as shown for an individual or family and paid for by a Member, after which – for the remainder of the [calendar year] [Contract Period] – UnitedHealthcare will pay 100% of the Allowed Charge for that Member's subsequent Covered Services under this Contract.]

Use this definition of Maximum Out-of-Pocket Expense with non-embedded HDHP Plans

[Maximum Out-of-Pocket Expense – the sum total amount of applicable Copayments, Coinsurance, and Deductibles, as shown for self-only or family coverage and paid by a Member, after which – for the remainder of the [calendar year] [Contract Period] – UnitedHealthcare will pay 100% of the Allowed Charge for that Member's subsequent Covered Services under this Contract. The total for self-only coverage applies when the Subscriber alone is covered by the Contract; the total for family coverage applies when the Subscriber and Eligible Dependents are covered by the Contract. If any supplemental benefits rider other than dental or vision is attached to the Contract, amounts paid by the Member in connection with such supplemental benefits rider will count toward any applicable Maximum Out-of-Pocket Expense. The following amounts will not count toward any applicable Maximum Out-of-Pocket Expense, and the Member's responsibility for paying these amounts will continue even after the Member has met any applicable Maximum Out-of-Pocket Expense: 1) amounts or charges in excess of the [MNRP rate][Maximum Allowance], whether or not paid by the Member and 2) penalty amounts payable by the Member for failing to comply with Preauthorization requirements set forth in the Contract]

Exclusions

Non-covered services include, but are not limited to: services not medically necessary • experimental procedures or treatments • personal or convenience items • custodial care • cosmetic services or surgery • reversal of sterilization • infertility • food or food supplements • over-the-counter drugs • dental, vision, hearing and prescription drugs (unless covered by supplemental benefit plan).

SERFF Tracking Number: UHLC-126680033 State: Arkansas
 Filing Company: UnitedHealthcare Insurance Company of the State Tracking Number: 45994
 River Valley
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: UnitedHealthcare of the River Valley
 Project Name/Number: /

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	07/08/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	07/08/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	07/08/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	07/08/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	07/08/2010
Bypass Reason:	N/A		
Comments:			

SERFF Tracking Number: UHLC-126680033 State: Arkansas
Filing Company: UnitedHealthcare Insurance Company of the State Tracking Number: 45994
River Valley
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: UnitedHealthcare of the River Valley
Project Name/Number: /

	Item Status:	Status
Satisfied - Item: Cover Letter	Approved-Closed	Date: 07/08/2010
Comments:		
Attachment:		
UHIC River Valley cover 6.16.10.pdf		

June 16, 2010,

Via U.S. Mail

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

NAIC: 12231 UnitedHealthcare Insurance Company of the River Valley

Form # UHC AR Plus COC 04-10
UHC AR Plus Schedule of Benefits 04/10

Dear Ms. Minor,

On behalf of UnitedHealthcare Insurance Company of the River Valley, please accept this correspondence as a submission of the above referenced filing for the Arkansas Insurance Department's ("the Department") review.

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

Respectfully,
Ebony N. Terry
Compliance Analyst
Enclosure
ENT