

SERFF Tracking Number: UHLC-126931158 State: Arkansas
Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 47439
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: AR 2011 COC et. al
Project Name/Number: /

Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: AR 2011 COC et. al

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: UHLC-126931158 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 47439

Co Tr Num:

Author: Ebony Terry

Date Submitted: 12/02/2010

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 01/28/2011

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type:

Group Market Type:

Filing Status Changed: 01/28/2011

State Status Changed: 01/28/2011

Created By: Ebony Terry

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

2011 Medical Necessity COC Filing

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Ebony Terry

Company and Contact

Filing Contact Information

Ebony Terry, Compliance Analyst

800 King Farm Blvd.

Ebony_N_Terry@uhc.com

240-632-8053 [Phone]

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Suite 500
 Rockville, MD 20850

Filing Company Information

UnitedHealthcare Insurance Company	CoCode: 79413	State of Domicile: Connecticut
185 Asylum Street	Group Code: 707	Company Type: Life and Health
Hartford, CT 06103	Group Name:	State ID Number:
(860) 702-5000 ext. [Phone]	FEIN Number: 36-2739571	

Filing Fees

Fee Required? Yes
 Fee Amount: \$600.00
 Retaliatory? No
 Fee Explanation: 12 Forms x 50.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company	\$600.00	12/02/2010	42585960

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/28/2011	01/28/2011

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	01/06/2011	01/06/2011
Pending Industry Response	Rosalind Minor	12/03/2010	12/03/2010

Response Letters

Responded By	Created On	Date Submitted
Ebony Terry	01/19/2011	01/19/2011
Ebony Terry	01/03/2011	01/03/2011

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Project Name/Number: /

Disposition

Disposition Date: 01/28/2011

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
Supporting Document	Forms List	Approved-Closed	Yes
Supporting Document (revised)	COC Redline	Approved-Closed	Yes
Supporting Document	COC Redline	Replaced	Yes
Form (revised)	COC	Approved-Closed	Yes
Form	COC	Replaced	Yes
Form	COC	Replaced	Yes
Form	Policy	Approved-Closed	Yes
Form	Schedule	Approved-Closed	Yes
Form	Schedule	Approved-Closed	Yes
Form	Schedule	Approved-Closed	Yes
Form	Schedule	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes
Form	Schedule	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes
Form	Schedule	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes
Form	Notice	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes

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Product Name: AR 2011 COC et. al
Project Name/Number: /

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 01/06/2011

Submitted Date 01/06/2011

Respond By Date

Dear Ebony Terry,

This will acknowledge receipt of the captioned filing.

Objection 1

- COC, COC.CER.I.11.AR (Form)

Comment:

On Page 47, under Coverage for a Disabled Dependent Child, it is stated that..."We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age....".

As stated in my previous objection letter, with respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Please remove the 31 day period. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Thank you for your cooperation.

Objection 2

- Rider, RDR.IFH.I.11.AR (Form)

Comment:

I am reviewing this rider and have a couple of questions. It is stated that to remain eligible for the "incentive plan" one must meeting certain crieria. Has our Department approved an "Incentive Plan"? If so, what was the approval date and the Form number.

If a person and/or their dependent, does not meet the criteria for eligibility to the incentive plan, do they have any coverage? If so, what plan?

I need further explanation with respect to the incentive plan.

Please feel free to contact me if you have questions.

Sincerely,

SERFF Tracking Number: UHLC-126931158 *State:* Arkansas
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TOI: H21 Health - Other *Sub-TOI:* H21.000 Health - Other
Product Name: AR 2011 COC et. al
Project Name/Number: /
Rosalind Minor

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TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: AR 2011 COC et. al
Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
Response Letter Date 01/19/2011
Submitted Date 01/19/2011

Dear Rosalind Minor,

Comments:

This communication shall serve as UnitedHealthcare Insurance Company's ("UHIC") response to your letter, dated January 06, 2011 regarding UHIC's submission of the above referenced filing submission, to the Arkansas Insurance Department. UHIC understands that this filing may not be issued or used for delivery in the state of Arkansas until formally approved by the Department. The revisions to the Filing have been made in accordance with the Department's comments and UHIC's response as identified below.

Response 1

Comments: The language has been deleted.

Related Objection 1

Applies To:

- COC, COC.CER.I.11.AR (Form)

Comment:

On Page 47, under Coverage for a Disabled Dependent Child, it is stated that...."We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age....".

As stated in my previous objection letter, with respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Please remove the 31 day period. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Thank you for your cooperation.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: COC Redline

SERFF Tracking Number: UHLC-126931158 State: Arkansas
 Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 47439
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: AR 2011 COC et. al
 Project Name/Number: /
 Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
COC	COC.CER	.I.11.AR	Certificate	Initial			AR 2011 COC Response 01.18.10.pdf
Previous Version							
COC	COC.CER	.I.11.AR	Certificate	Initial			AR 2011 COC Response 01.03.10.pdf
COC	COC.CER	.I.11.AR	Certificate	Initial			AR INS 2011 COC.pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: The incentive plan and the base plan both come from our existing portfolios of approved plans. When the Incentives for Health rider is purchased by the enrolling group, the employer will offer two plans to their employees, the incentive plan (with a lower deductible) and the base plan (with a higher deductible) but will have the same underlying benefits, deductible, coinsurance and copayments.

In order to qualify for the incentive plan, Individuals need to go to the MD, have their MD sign off on a number of biometric screens and submit a form. When the form is received (regardless of how the individual did on their biometric results), the member is "compliant" and eligible to stay in the incentive plan for 2 years. If individuals do not complete their screens and submit the form, they are considered "non compliant" from an eligibility perspective based on the employer groups requirements, therefore, will be bumped to the base plan year 2, which will have a higher deductible but the same covered benefits.

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Product Name: AR 2011 COC et. al
Project Name/Number: /

The individual would not be excluded from coverage altogether, they would just simply not be eligible for the incentive plan.

Related Objection 1

Applies To:

- Rider, RDR.IFH.I.11.AR (Form)

Comment:

I am reviewing this rider and have a couple of questions. It is stated that to remain eligible for the "incentive plan" one must meeting certain criteria. Has our Department approved an "Incentive Plan"? If so, what was the approval date and the Form number.

If a person and/or their dependent, does not meet the criteria for eligibility to the incentive plan, do they have any coverage? If so, what plan?

I need further explanation with respect to the incentive plan.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

If you have any additional questions please contact me at Ebony_N_Terry@uhc.com, 240.632.8056 or through the SERFF messaging system.

Sincerely,
Ebony Terry

SERFF Tracking Number: UHLC-126931158

State: Arkansas

Filing Company: UnitedHealthcare Insurance Company

State Tracking Number: 47439

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: AR 2011 COC et. al

Project Name/Number: /

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 12/03/2010

Submitted Date 12/03/2010

Respond By Date

Dear Ebony Terry,

This will acknowledge receipt of the captioned filing.

Objection 1

- COC, COC.CER.I.11.AR (Form)

Comment:

Under the provision for coverage for a disabled dependent child, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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 Company Tracking Number:
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 Product Name: AR 2011 COC et. al
 Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
 Response Letter Date 01/03/2011
 Submitted Date 01/03/2011

Dear Rosalind Minor,

Comments:

This mailing shall serve as United HealthCare Insurance Company's, ("UHIC") response to your letter, dated December 3, 2010 regarding UHIC's submission of the above referenced Group Health Forms to the Arkansas Insurance Department (the "Department"). UHIC understands that these Forms may not be issued or used for delivery in the state of Arkansas until formally approved by the Department. I am enclosing one revised copy of the COC as well as an additional form for your review. Please see the "Incentives for Health Rider" form below. The revisions to the Certificate have been made in accordance with the Department's comments.

Response 1

Comments: The provision has been revised accordingly.

Related Objection 1

Applies To:

- COC, COC.CER.I.11.AR (Form)

Comment:

Under the provision for coverage for a disabled dependent child, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: COC Redline

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document

<i>SERFF Tracking Number:</i>	<i>UHLC-126931158</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>UnitedHealthcare Insurance Company</i>	<i>State Tracking Number:</i>	<i>47439</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
<i>Product Name:</i>	<i>AR 2011 COC et. al</i>		
<i>Project Name/Number:</i>	<i>/</i>		
COC	COC.CER .I.11.AR	Certificate	Initial
			AR 2011 COC Response 01.03.10.p df
Previous Version			
COC	COC.CER .I.11.AR	Certificate	Initial
			AR INS 2011 COC.pdf
Rider	RDR.IFH.I .11.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Initial
			AR INS 2011 ICH RDR.pdf

No Rate/Rule Schedule items changed.

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

Sincerely,
Ebony Terry

SERFF Tracking Number: UHLC-126931158

State: Arkansas

Filing Company: UnitedHealthcare Insurance Company

State Tracking Number: 47439

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: AR 2011 COC et. al

Project Name/Number: /

Form Schedule

Lead Form Number: POL.I.11.AR et al.

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/28/2011	COC.CER.I.11.AR	Certificate	COC	Initial			AR 2011 COC Response 01.18.10.pdf
Approved-Closed 01/28/2011	POL.I.11.A.R	Policy/Cont ract/Fratern al Certificate	Policy	Initial			AR INS 2011 POL.pdf
Approved-Closed 01/28/2011	SBN.CHP.I.11.AR	Schedule Pages	Schedule	Initial			AR INS 2011 CHCPLS SBN.pdf
Approved-Closed 01/28/2011	SBN.OPT.I.11.AR	Schedule Pages	Schedule	Initial			AR INS 2011 OPT SBN.pdf
Approved-Closed 01/28/2011	SBN.NDF.I.11.AR	Schedule Pages	Schedule	Initial			AR INS 2011 NONDIFF SBN.pdf
Approved-Closed 01/28/2011	RDR.RXSB.N.PLS.I.11.AR	Schedule Pages	Schedule	Initial			AR INS 2011 PLS RXSBN.pdf
Approved-Closed 01/28/2011	RDR.RX.PLS.I.11.AR	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Rider	Initial			AR INS 2011 PLS RDR.pdf
Approved-Closed	RDR.GEN.RXSBN.PL	Schedule Pages	Schedule	Initial			AR INS 2011 GEN PLS

SERFF Tracking Number:	UHLC-126931158	State:	Arkansas
Filing Company:	UnitedHealthcare Insurance Company	State Tracking Number:	47439
Company Tracking Number:			
TOI:	H21 Health - Other	Sub-TOI:	H21.000 Health - Other
Product Name:	AR 2011 COC et. al		
Project Name/Number:	/		
01/28/2011 S.I.11.AR			SBN.pdf
Approved- RDR.GEN Policy/Cont Rider		Initial	AR INS 2011
Closed RX.PLS.I.1 ract/Fratern			GEN PLS
01/28/2011 1.AR	al		RDR.pdf
	Certificate:		
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- RDR.SHAR Schedule	Schedule	Initial	AR INS 2011
Closed ERXSBN.P Pages			SHARE RX
01/28/2011 LS.I.11.AR			PLS SBN.pdf
Approved- RDR.SHAR Policy/Cont Rider		Initial	AR INS 2011
Closed ERX.PLS.I. ract/Fratern			SHARE RX
01/28/2011 11.AR	al		PLS RDR.pdf
	Certificate:		
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- EXB2NTC.I Notice of	Notice	Initial	AR INS 2011
Closed .11.AR Coverage			NTC.pdf
01/28/2011			
Approved- RDR.IFH.I. Certificate	Rider	Initial	AR INS 2011
Closed 11.AR Amendmen			ICH RDR.pdf
01/28/2011	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		

Certificate of Coverage

UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy

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

In addition to this *Certificate* the Policy includes:

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

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

Changes to the Document

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

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

Other Information You Should Have

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

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

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

We are delivering the Policy in the State of [\[State Name Here\]](#). The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of [\[State Name Here\]](#) are the laws that govern the Policy.

Introduction to Your Certificate

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

How to Use this Document

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

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

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

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

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

Information about Defined Terms

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

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

Don't Hesitate to Contact Us

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

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

Arkansas Insurance Department
[Consumer Services Division]
[1200 West Third Street]
[Little Rock, AR 72201-1904]
[(800) 852-5494] or [(501) 371-2640]

Your Responsibilities

Be Enrolled and Pay Required Contributions

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

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

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

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

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

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

[Product Variables:]

[¹Choice Plus or Options PPO when network providers are responsible for prior authorization.]

[²Choice.]

[³Options PPO when network providers are not responsible for prior authorization or Non-Differential PPO when prior authorization is required for any service.]

Some Covered Health Services require prior authorization. [¹In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services.] [²In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services.] [³You are responsible for obtaining authorization before you receive the services.] For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

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

Pay the Cost of Excluded Services

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

Show Your ID Card

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

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

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

We have the discretion to do the following:

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

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

Pay for Our Portion of the Cost of Covered Health Services

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

Pay Network Providers

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

Pay for Covered Health Services Provided by Non-Network Providers

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

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

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

Offer Health Education Services to You

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

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Section 1: Covered Health Services

Benefits for Covered Health Services

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

[Here and throughout the document, the defined term (capitalized) applies if Mental Health Benefits are sold, lower case reference applies if Mental Health Benefits are not sold.]

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 9: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, [\[Mental Illness,\]](#) [\[mental illness,\]](#) substance use disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Policy.
- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

[Bracketed plan features are plan design variable.]

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

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

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

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design. Include any other specific conditions for coverage described within the category.]

[1.] [Acupuncture Services]

[\[Acupuncture services for the following conditions:](#)

- [Pain therapy.](#)
- [Nausea that is related to surgery, Pregnancy or chemotherapy.](#)

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

- [Doctor of Medicine.](#)
- [Doctor of Osteopathy.](#)

- [Chiropractor.](#)
- [Acupuncturist.\]](#)

[2.] Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where Emergency Health Services can be performed.

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

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

[3.] Clinical Trials

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

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

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

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

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

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

Routine patient care costs for clinical trials include:

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

Routine costs for clinical trials do not include:

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

- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

- Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.
 - *Centers for Medicare and Medicaid Services (CMS)*.
 - *Department of Defense (DOD)*.
 - *Veterans Administration (VA)*.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

[4.] [Congenital Heart Disease Surgeries]

[Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

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

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

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

[5.] [Dental Services - Accident Only]

[Dental services when all of the following are true:

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

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

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

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

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

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.]

[6.] Diabetes Services

Diabetes Self-Management Training is mandated in Arkansas.

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

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

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

Diabetic Self-Management Items

[Include paragraph below when group purchases the drug rider.]

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

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

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

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

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

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

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

[7.] [Durable Medical Equipment]

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

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

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

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of Durable Medical Equipment include:

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

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

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

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

Benefits are available for repairs and replacement, except that:

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

[Include when DME benefit is tiered and tiers are not to be included in COC.]

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

[Include when DME benefit is tiered and tiers are to be included in COC.]

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

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

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

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

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

[8.] Emergency Health Services - Outpatient

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

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

[Include if plan design includes retrospective review of emergency services.]

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

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

[9.] Hearing Aids

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

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

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

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.]

[10.] Home Health Care

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

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

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

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

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

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

[11.] Hospice Care

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

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

[12.] Hospital - Inpatient Stay

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

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

[13.] [Infertility Services]

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

- Ovulation induction.
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Assisted Reproductive Technologies (ART).
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

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

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

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

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

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility *[or in a Physician's office]* include:

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

Benefits under this section include:

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

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

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

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

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient*.

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

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

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

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.

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

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

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

[Include as standard for groups of 2 to 15]

[16.] [Mental Health Services]

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

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.]

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

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

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.

- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

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

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

[Include when expanded services for autism are required by state law. If there is not a state mandate requiring coverage ABA, delete this provision. It is not available for sale at a group specific level.]

[Note to contract specialist: This section should only be utilized to support the mental health component of state mandates for autism spectrum disorders for intensive behavioral therapies such as ABA. Delete this instruction prior to filing.]

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

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.]

[18.] [Obesity Surgery]

[Include the applicable criteria for coverage].

[Surgical treatment of obesity when provided by or under the direction of a Physician [when the Covered Person has a body mass index (BMI) greater than 40].

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

- [The Covered Person must have a body mass index (BMI) of greater than 40.]
- [The Covered Person must have a body mass index (BMI) of greater than 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by, obesity.]]

[19.] [Ostomy Supplies]

[Benefits for ostomy supplies are limited to the following:

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

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

[20.] Pharmaceutical Products - Outpatient

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

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

[Pharmaceutical Products are assigned to various tiers. The Pharmaceutical Product List Management Committee makes the final classification of a Pharmaceutical Product to a certain tier by considering a number of factors including clinical and economic factors. Clinical factors may include evaluations of the place in therapy, relative safety or relative efficacy of the Pharmaceutical Product, as well as whether prior authorization requirements should apply. Economic factors may include the Pharmaceutical Product's acquisition cost, including available rebates and assessments on the cost effectiveness of the Pharmaceutical Product.

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

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

[If you require certain Pharmaceutical Products[, including specialty Pharmaceutical Products,] we may direct you to a Designated Dispensing Entity with whom we have an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

[¹ Applies to Choice Plus and Options PPO products.]

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, [¹Network] Benefits are not available for that Pharmaceutical Product.]

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

[Benefits for certain Pharmaceutical Products are subject to the supply limits that are stated in the *Schedule of Benefits*. For a single Copayment and/or Coinsurance, you may receive Pharmaceutical Products up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per order or refill and/or the amount dispensed per month's supply.

You may determine whether a Pharmaceutical Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

[21.] Physician Fees for Surgical and Medical Services

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

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

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

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

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

[¹Include when Genetic Testing must be preceded by genetic counseling.]

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is [¹determined to be Medically Necessary following genetic counseling when] ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[24.] Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Prosthetics are a mandated benefit in Arkansas.

[25.] Prosthetic Devices and Services

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

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

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

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

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

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

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

[26.] Reconstructive Procedures

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

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

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

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

[Short-term outpatient rehabilitation services, limited to:

- Physical therapy.
- Occupational therapy.
- [Manipulative Treatment.]
- Speech therapy.
- Pulmonary rehabilitation therapy.

- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.
- [Vision therapy.]

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

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

[Here and throughout the document, include defined capitalized term if plan design includes benefits for neurobiological disorder/autism spectrum disorder services. Include lower case reference if plan design does not include benefits for neurobiological disorder/autism spectrum disorder services.]

Please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or [autism spectrum disorders] [Autism Spectrum Disorders]. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.]

[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

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

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

Benefits under this section include:

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

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

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

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

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

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

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

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

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

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

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

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

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

[Include as standard for groups of 2 to 15]

[30.] Substance Use Disorder Services

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

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.]

[31.] Surgery - Outpatient

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

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

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

[¹Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.]

Benefits under this section include:

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

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

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

[32.] Temporomandibular Joint Services

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

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

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

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

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

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.

[33.] Therapeutic Treatments - Outpatient

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

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility [\[or in a Physician's office\]](#), including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

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

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

Benefits under this section include:

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

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

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

[34.] Transplantation Services

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

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

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

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

[35.] Urgent Care Center Services

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

[36.] [Vision Examinations]

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

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

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

[37.] [Wigs]

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

Additional Benefits Required By Arkansas Law

[38.] Dental Services - Anesthesia and Hospitalization

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

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

[39.] In Vitro Fertilization Services

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

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

[40.] Medical Foods

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

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

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

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

[[42.] Orthotic Devices and Services

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

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

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

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

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

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

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

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

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

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

Section 2: Exclusions and Limitations

How We Use Headings in this Section

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

We do not Pay Benefits for Exclusions

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

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

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

Benefit Limitations

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

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

[Include bracketed variable exclusions below to support plan design. Unbracketed exclusions will always appear.]

A. Alternative Treatments

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

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).[\[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.\]](#) [Dental Services - Anesthesia and Hospitalization](#) for which Benefits are provided as described in *Section 1: Covered Health Services*.

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

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

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

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

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

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

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. *This exclusion does not apply to orthotics as described under Durable Medical Equipment in Section 1: Covered Health Services.*
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses.
 - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech [except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment in Section 1: Covered Health Services.*]
6. Oral appliances for snoring.

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

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

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.

[6.] [Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.]

[7.] [New Pharmaceutical Products and/or new dosage forms until the date they are assigned to a tier by our Pharmaceutical Product List Management Committee.]

E. Experimental or Investigational or Unproven Services

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

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

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
 - Cleaning and soaking the feet.
 - Applying skin creams in order to maintain skin tone.

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

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

^[1]Applies when plan design does not include benefits for durable medical equipment.]

^[2]Applies when plan design includes benefits for durable medical equipment.]

G. Medical Supplies [¹and Equipment]

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:

- Compression stockings.
- Ace bandages.
- Gauze and dressings.
- Urinary catheters.
- [Ostomy supplies.]

This exclusion does not apply to:

- [²Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment in Section 1: Covered Health Services.*]
- Diabetic supplies for which Benefits are provided as described under *Diabetes Services in Section 1: Covered Health Services.*
- [Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies in Section 1: Covered Health Services.*]

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

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

H. Mental Health

[Introductory sentence and exclusions 1-9 apply when plan design includes benefits for mental health services.]

[Exclusion 10 applies when plan design does not include benefits for mental health services. Renumber exclusion to #1.]

[Exclusions listed directly below apply to services described under *Mental Health Services in Section 1: Covered Health Services.*]

- [1.] [Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*]
- [2.] [Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*]
- [3.] [Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.]
- [4.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.]
- [5.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.]
- [6.] [Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act.*]
- [7.] [Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*]
- [8.] [Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.* Benefits

for autism spectrum disorder as a primary diagnosis are described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.]

- [9.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
 - Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.]

[¹Applies when the group provides benefits for mental health services under a separate plan.]

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

I. Neurobiological Disorders - Autism Spectrum Disorders

[Introductory sentence and exclusions 1-8 apply when plan design includes benefits for neurobiological disorder/autism spectrum disorder services.]

[Exclusion 9 applies when plan design does not include benefits for neurobiological disorder/autism spectrum disorder services. Renumber exclusion to #1.]

[Exclusions listed directly below apply to services described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.]

- [1.] [Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]
- [2.] [Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.]
- [3.] [Mental retardation as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]
- [4.] [Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.]
- [5.] [Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.]
- [6.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.]

[Applies when plan design does not include benefits for expanded autism spectrum disorder.]

- [7.] [Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder.]
- [8.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.

- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.]

[Applies when plan design does not include benefits for neurobiological disorder/autism spectrum disorder services.]

[¹Applies when the group provides benefits for autism spectrum disorders under a separate plan.]

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

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
 - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
 - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
2. Enteral feedings, even if the sole source of nutrition. **This exclusion does not apply to medical foods for which Benefits are provided as described in *Section 1: Covered Health Services***
3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

K. Personal Care, Comfort or Convenience

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

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

L. Physical Appearance

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

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

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

[Applies when plan design does not provide benefits for pre-existing conditions.]

[M.] [Preexisting Conditions]

[A 12-month preexisting condition exclusion applies to all covered persons age 19 and older.]

[1.] [Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months. This exclusion does not apply to Covered Persons under age 19.]

[A 12-month preexisting condition exclusion applies to timely adds and an 18-month preexisting condition exclusion to late enrollees.]

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

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

This exclusion does not apply to Covered Persons under age 19.]

[A preexisting condition exclusion applies to late enrollees only.]

[1.] [Benefits for the treatment of a Preexisting Condition are excluded for Late Enrollees until the date you have had Continuous Creditable Coverage for [12] [18] months. This exclusion does not apply to Covered Persons under age 19.]

[N.] Procedures and Treatments

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

[Applies when plan design includes benefits for rehabilitation services.]

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

[Applies when plan design includes benefits for rehabilitation services.]

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

[Applies when plan design includes benefits for rehabilitation services.]

[6.] [Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.]

[Applies when plan design does not include benefits for rehabilitation services.]

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

[6.] Psychosurgery.

- [7.] Sex transformation operations and related services.
- [8.] Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
- [9.] Biofeedback.

[Applies when plan design does not include benefits for manipulative treatment.]

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

[Applies when plan design does not include benefits for TMJ.]

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

[Applies when plan design includes benefits for TMJ.]

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

¹Include if group purchases optional benefit for Musculoskeletal Disorders.

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

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

- [14.] Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

[Applies when plan design does not include benefits for breast reduction.]

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

[Applies when plan design includes benefits for breast reduction.]

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

[Applies when plan design requires that implantation of ventricular assist devices be performed at a Designated Facility.]

- [17.] [Ventricular assist device implantation that is not performed at a Designated Facility. This exclusion does not apply to partial assist devices which are intended for short-term purposes or to Emergency implantations of partial assist devices.]

[Applies when plan design requires that Network Benefits for implantation of ventricular assist devices be performed at a Designated Facility.]

[18.] [Network Benefits for ventricular assist device implantation that is not performed at a Designated Facility. This exclusion does not apply to partial assist devices which are intended for short-term purposes or to Emergency implantations of partial assist devices.]

[O.] Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

- Has not been actively involved in your medical care prior to ordering the service, or
- Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography.

[P.] Reproduction

[Applies when plan design does not include benefits for infertility treatment.]

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

[Applies when plan design includes benefits for infertility treatment.]

[The following infertility treatment-related services:

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

[Applies when plan design does not include benefits for infertility treatment.]

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

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

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

[6.] [Contraceptive supplies and services.]

[Will not apply when plan design includes benefits for infertility treatment.]

[7.] [Fetal reduction surgery.]

[Applies when plan design does not include full maternity benefits. This option is available only to groups with 14 or fewer employees.]

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

[Q.] Services Provided under another Plan

[Applies when plan design does not include benefits for 24 hour coverage.]

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

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

[Applies when plan design includes benefits for 24 hour coverage.]

- [Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes coverage required by workers' compensation, no-fault auto insurance, or similar legislation. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.]
2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

[R.] Substance Use Disorders

[Introductory sentence and exclusions 1-4 apply when plan design includes benefits for substance use disorder services.]

[Exclusion 5 applies when plan design does not include benefits for substance use disorder services. Renumber exclusion to #1.]

[Exclusions listed directly below apply to services described under *Substance Use Disorder Services in Section 1: Covered Health Services.*]

- [1.] [Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*]
- [2.] [Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.]
- [3.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.]
- [4.] [Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.

- Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.]

[Applies when plan does not include benefits for substance use disorders.]

[¹Applies when the group provides benefits for substance use disorders under a separate plan.]

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

[S.] Transplants

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

[Applies to Network-only plans and to plans with Network and Non-Network benefits when Non-Network transplant benefits are not available and plan design requires transplants to take place at Designated Facilities.]

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

[T.] Travel

1. [Health services provided in a foreign country, unless required as Emergency Health Services.]
- [2.] Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services*.

[U.] Types of Care

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

[V.] Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses.

- [2.] [Routine vision examinations, including refractive examinations to determine the need for vision correction.]
- [3.] Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
- [4.] [Eye exercise or vision therapy.]
- [5.] Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.

[Applies when plan design provides benefits for hearing aids.]

- [6.] [Bone anchored hearing aids except when either of the following applies:
 - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
 - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

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

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

[Applies when plan design does not provide benefits for hearing aids.]

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

[W.] All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - ◆ Medically Necessary.
 - ◆ Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
 - ◆ Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
 - Required solely for purposes of school, sports or camp[, travel,] [career or employment,] insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.
 - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services.
11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins

How to Enroll

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

If You Are Hospitalized When Your Coverage Begins

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

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

[Applies when plan design includes Medicare estimating.]

[If You Are Eligible for Medicare]

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

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

Who is Eligible for Coverage

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

Eligible Person

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

[Eligible Persons must reside within the United States.]

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

Dependent

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

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

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

When to Enroll and When Coverage Begins

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

Initial Enrollment Period

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

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

[Applies when the Incentives for Health Rider is sold.]

[During this Initial Enrollment Period, the Enrolling Group will offer an incentive plan as described in the [Incentives for Health] Rider which is attached to this *Certificate*. In order to enroll in the [Incentives for Health] [in subsequent years] you must meet the eligibility requirements stated in the Rider.]

[Open Enrollment Period]

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

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

Dependent Child Special Open Enrollment Period

On or before the first day of the first plan year beginning on or after September 23, 2010, the Enrolling Group will provide a 30 day dependent child special open enrollment period for Dependent children who are not currently enrolled under the Policy and who have not yet reached the limiting age. During this dependent child special open enrollment period, Subscribers who are adding a Dependent child and who have a choice of coverage options will be allowed to change options.

Coverage begins on the first day of the plan year beginning on or after September 23, 2010, if we receive the completed enrollment form and any required Premium within 31 days of the date the Dependent becomes eligible to enroll under this special open enrollment period.

New Eligible Persons

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

Adding New Dependents

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- [\[Registering a Domestic Partner.\]](#)

Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption, court or administrative order, or marriage will take effect on the date of the event. Coverage is effective only if

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

Special Enrollment Period

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

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

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- [\[Registering a Domestic Partner.\]](#)

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

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period [\[or Open Enrollment Period\]](#); and
- Coverage under the prior plan ended because of any of the following:
 - Loss of eligibility (including legal separation, divorce or death).
 - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
 - In the case of COBRA continuation coverage, the coverage ended.
 - The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
 - The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
 - An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.
 - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event if we receive the completed enrollment form and 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.

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

[Include if group chooses to allow Late Enrollees to enroll and applies the Late Enrollee preexisting condition.]

[Late Enrollees]

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

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

Section 4: When Coverage Ends

General Information about When Coverage Ends

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

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

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). **[Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.]**

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

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

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

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

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

- **You Are No Longer Eligible**

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

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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

Other Events Ending Your Coverage

When either of the following happens, we will provide advance written notice to the Subscriber that coverage will end on the date we identify in the notice:

- **Fraud or Intentional Misrepresentation of a Material Fact**

You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent.

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

- **Threatening Behavior**

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

Coverage for a Disabled Dependent Child

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

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

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

We will ask you to furnish us with proof of the medical certification of disability. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

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

[Extended Coverage for Total Disability]

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

- The Total Disability ends.
- [Three - Eighteen] months from the date coverage would have ended when the entire Policy was terminated.]

Extended Coverage if You are Hospitalized

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

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

The date your Inpatient Stay ends, or

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

Continuation of Coverage and Conversion

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal [²⁻³or state] law.

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

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

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

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

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

Qualifying Events for Continuation Coverage under State Law

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

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

Notification Requirements and Election Period for Continuation Coverage under State Law

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

Terminating Events for Continuation Coverage under State Law

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

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

[³Continuation Coverage under State Law (Mini-COBRA)]

[³Continuation coverage under state law is available to you if you have been enrolled for coverage under the Policy for a continuous period of three months prior to the date coverage terminates and if your

coverage ends under the Policy as described below. This continuation applies to you if the Enrolling Group is an eligible small business with between 2-19 employees. Continuation coverage under state law is available to Enrolling Groups that are not subject to the terms of COBRA. You should call your Enrolling Group's plan administrator if you have questions about your right to continue coverage under state law.

Continuation coverage under state law is available for any of the following persons who was covered under the Policy on the day before a qualifying event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.

Continuation coverage is not available for any person who:

- Is covered or is eligible for coverage under Medicare.
- Fails to verify that he or she is ineligible for employer-based group health insurance as an eligible dependent.
- Is or could be covered by any other insured or uninsured arrangement which provides hospital, surgical or major medical coverage for individuals in a group.]

[³Qualifying Events for Continuation Coverage under State Law (Mini-COBRA)]

[³If coverage would ordinarily terminate due to one of the following qualifying events, then you are entitled to continue coverage. You are entitled to elect the same coverage that you had on the day before the qualifying event.

Qualifying events are:

- Termination of the Subscriber from employment with the Enrolling Group.
- Death of the Subscriber.
- Divorce or legal separation of the Subscriber.
- Loss of eligibility by an Enrolled Dependent who is a child.]

[³Notification Requirements and Election Period for Continuation Coverage under State Law (Mini-COBRA)]

[³The Enrolling Group's plan administrator must notify the Subscriber and us of a qualifying event within 30 days of the qualifying event. Notice to the Subscriber must include notices of the rights described in this section.

The Subscriber and/or Enrolled Dependent must notify the Enrolling Group's plan administrator of election of continuation coverage within 30 days of receiving notice as described above. You should obtain an election form from the Enrolling Group's plan administrator and, once election is made, forward any monthly premiums to the Enrolling Group for payment to us.]

[³Terminating Events for Continuation Coverage under State Law (Mini-COBRA)]

[³Continuation under the Policy will end on the earliest of the following dates:

- Nine months from the date of the qualifying event.
- The date coverage terminates under the Policy for failure to make timely payment of the Premium.

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you first become entitled to Medicare.
- The date the entire Policy ends.
- The date coverage would otherwise terminate under the Policy as described above under *Events Ending Your Coverage*.]

[¹Conversion]

[¹If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

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

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

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

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

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

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

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

Required Information

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

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

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

[\[Name of Pharmacy Benefit Manager\]](#)

[\[Address of Pharmacy Benefit Manager\]](#)

[\[City, State and Zip Code\]](#)

Payment of Benefits

[\[Applies when assignment of benefits is agreed to.\]](#)

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

[Benefits will be paid to you unless either of the following is true:](#)

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

[Applies when assignment of benefits is not agreed to.]

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

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

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

Section 6: Questions, Complaints and Appeals

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

What to Do if You Have a Question

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

What to Do if You Have a Complaint

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

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

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

How to Appeal a Claim Decision

Post-service Claims

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

Pre-service Requests for Benefits

[Include if prior authorization includes determining alternate levels of benefits.]

Pre-service requests for Benefits are those requests that require prior authorization or benefit confirmation prior to receiving medical care. [\[If we adjust Eligible Expenses for identified Covered Health Services based on Generally Accepted Standards of Medical Practice, which for some Covered Health Services may be addressed in our clinical policies, you may appeal that decision pursuant to this process.\]](#)

How to Request an Appeal

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

Your request for an appeal should include:

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

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

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

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

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

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

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

Our decision is based on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

Urgent Appeals that Require Immediate Action

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

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

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

Include when the state does not have the required external review process in place.

[Federal External Review Program]

[The *Departments of Health and Human Services, Labor and Treasury (Departments)* will establish a Federal external review process which will be available in those jurisdictions where no State external review process is in effect. Where applicable, once the process has been established by the *Departments*, we will provide you with additional information concerning the process.

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

Include when the voluntary external review program applies.

[Voluntary External Review Program]

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

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

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

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

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

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

When Coordination of Benefits Applies

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

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

Definitions

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

- A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
 - 1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 - 2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

- D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
 2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
 3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
 5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.
- E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations

are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
 - 2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
 - b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
 - (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
 - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
 - (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the Custodial Parent.
 - (b) The Plan covering the Custodial Parent's spouse.
 - (c) The Plan covering the non-Custodial Parent.
 - (d) The Plan covering the non-Custodial Parent's spouse.

- c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

[Applies when plan design includes Medicare estimating.]

- C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D].
- The person is enrolled in a *Medicare Advantage* (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D].

- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D] and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a *Medicare Medical Savings Account*. Medicare benefits are determined as if the person were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D].]

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

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

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Enrolling Group's Benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this *Certificate*.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of the termination of the Policy.

When the Enrolling Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers and Enrolling Groups

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Enrolling Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

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

Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician.

These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. [\[We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.\]](#) [\[We pass these rebates on to you, and they are applied to any deductible and taken into account in determining your Copayments or Coinsurance.\]](#)

Interpretation of Benefits

We have the sole and exclusive discretion to do all of the following:

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

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

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

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or

required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

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

[Applies when plan design includes Medicare estimating.]

[Medicare Eligibility]

[Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Policy.]

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under [both Medicare Part A and Part B] [Medicare Parts A, B and D] [Medicare Part D]. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in *Section 7: Coordination of Benefits*, we will pay Benefits under the Policy as if you were covered under [both Medicare Part A and Part B] [Medicare Parts A, B and D] [Medicare Part D]. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. You will

be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.]

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this *Certificate*, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
 - Providing any relevant information requested by us.
 - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or injuries.
 - Making court appearances.
 - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or

judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.

- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date

we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*, the Enrolling Group's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 9: Defined Terms

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

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

[An Alternate Facility may also provide [Mental Health Services] [or] [Substance Use Disorder Services] on an outpatient or inpatient basis.]

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

[**Annual Maximum Benefit** - for Benefit plans that have an Annual Maximum Benefit, this is the maximum amount that we will pay for Benefits during the year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Annual Maximum Benefit and for details about how the Annual Maximum Benefit applies.]

[Applies when plan design includes benefits for infertility services.]

[**Assisted Reproductive Technology (ART)** - the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).]

[Applies when plan design includes benefits for neurobiological disorder/autism spectrum disorder services.]

[**Autism Spectrum Disorders** - a group of neurobiological disorders that includes *Autistic Disorder, Rhetts Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder and Pervasive Development Disorders Not Otherwise Specified (PDDNOS)*.]

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits* and any attached Riders and/or Amendments.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

[For Pharmaceutical Products, your Coinsurance is determined by the tier to which the *Pharmaceutical Product List Management Committee* has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

[Complications of Pregnancy - a condition that requires treatment during a Pregnancy or during the post-partum period.]

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

[Continuous Creditable Coverage - health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services and for their dependents.
- A medical care program of the *Indian Health Services Program* or a tribal organization.
- A state health benefits risk pool.
- *The Federal Employees Health Benefits Program*.
- *The State Children's Health Insurance Program (S-CHIP)*.
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the *Peace Corps Act*.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.]

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

[For Pharmaceutical Products, your Copayment is determined by the tier to which the *Pharmaceutical Product List Management Committee* has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this *Certificate* are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

[Options related to dependent eligibility are variable based upon the group's benefit plan eligibility rules.]

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. *[All references to the spouse of a Subscriber shall include a Domestic Partner.]* The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

[The definition of Dependent also includes parents [and grandparents] of the Subscriber [or the Subscriber's spouse] [or such other sponsored Dependents as agreed upon by us and the Enrolling Group].]

[To be eligible for coverage under the Policy, a Dependent must reside within the United States.]

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under *[26 - 30]* years of age.
- A Dependent includes an unmarried dependent child age *[26 - 30]* or older who is or becomes disabled and dependent upon the Subscriber.

[A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the date the child reaches age [26 - 30].]

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

[A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.]

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity.]

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

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

[Domestic Partnership - a relationship between a Subscriber and one other person of the [opposite sex] [same sex] [opposite or same sex]. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.

^[1]Applies if group requires documentation of financial interdependence.]

- They must be financially interdependent ^[1]and they have furnished documents to support at least two of the following conditions of such financial interdependence:
 - [They have a single dedicated relationship of at least [6 - 18] months duration.]
 - [They have joint ownership of a residence.]
 - [They have at least two of the following:
 - ◆ A joint ownership of an automobile.
 - ◆ A joint checking, bank or investment account.
 - ◆ A joint credit account.
 - ◆ A lease for a residence identifying both partners as tenants.
 - ◆ A will and/or life insurance policies which designates the other as primary beneficiary].]

^[2]Include if group requires signed affidavit.]

^[2]The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.]]

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.

- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. [\[An Eligible Person must reside within the United States.\]](#)

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or [\[Mental Illness\]](#)[\[mental illness\]](#) which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Enrolling Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.

- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Intensive Outpatient Treatment - a structured outpatient [mental health] [or] [substance use disorder] treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.]

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

[Late Enrollee - an Eligible Person or Dependent who enrolls for coverage under the Policy at a time other than the following:

- During the Initial Enrollment Period.
- During an Open Enrollment Period.
- During a special enrollment period as described in *Section 3: When Coverage Begins*.
- Within 31 days of the date a new Eligible Person first becomes eligible.]

- **Low Protein Modified Food Product** - a food product specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an Inherited Metabolic Disease under the direction of a Physician

[Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.]

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, [Mental Illness,] [mental illness,] substance use disorder, condition, disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, [Mental Illness,] [mental illness,] substance use disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

[Applies when plan design includes benefits for mental health services or neurobiological disorder/autism spectrum disorder services.]

[Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.]

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Mental Health/Substance Use Disorder Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.]

[Applies when plan design includes benefits for mental health services or neurobiological disorder/autism spectrum disorder services.]

[Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.]

[Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.]

[Applies when the Shared Savings Program is included. "Shared Savings Program" is bracketed to accommodate possible name change. This Shared Savings Program reference will not be included in a Choice COC.]

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services [\[by way of their participation in the \[Shared Savings Program\]\]](#). Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

[Applies when plan design does not include benefits for new pharmaceutical products.]

[New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product, for the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our Pharmaceutical Product List Management Committee.
- December 31st of the following calendar year.]

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

[Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.]

Orthotic Device - an external device that is, (i) intended to restore physiological function or cosmesis to a Covered Person; and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the Covered Person using the device prior to concurrent with the delivery of the device to the Covered Person.

Orthotic Service - the evaluation and treatment of a condition that requires the use of an Orthotic Device.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Partial Hospitalization/Day Treatment] - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.]

[Per Occurrence Deductible] - for Benefit plans that have a Per Occurrence Deductible, this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

When a Benefit plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of a Per Occurrence Deductible and for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.]

Pharmaceutical Product(s) - U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Pharmaceutical Product List - a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration (FDA). This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Pharmaceutical Product has been assigned through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Pharmaceutical Product List Management Committee - the committee that we designate for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

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

These documents make up the entire agreement that is issued to the Enrolling Group.

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

[Preexisting Condition] - an Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the [three] [six] month period ending on the person's

enrollment date. (The enrollment date is the date the person became covered under the Policy or, if earlier, the first day of any waiting period under the Policy.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.]

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

¹Applies when OB/GYN Physicians are considered Primary Physicians.]

²Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services and all clinicians are considered primary physicians.]

³Applies when clinicians providing psychological testing are not considered specialists.]

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, [¹obstetrics/gynecology,] family practice or general medicine. [²For [Mental Health Services] [and] [Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Primary Physician [³for the provision of all services other than psychological testing].]

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Prosthetic Device - an external device that is (i) intended to replace an external body part for the purpose of restoring physiological function or cosmesis to a patient; and (ii) custom designed, fabricated, assembled, fitted, or adjusted for patient using the device prior to or concurrent with being delivered to the Covered Person.

Prosthetic Service - the evaluation and treatment of a condition that requires the use of a Prosthetic Device.

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Residential Treatment Facility - a facility which provides a program of effective [Mental Health Services] [or] [Substance Use Disorder Services] treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.

- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.]

Rider - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

[Applies when the Shared Savings Program is included. "Shared Savings Program" is bracketed to accommodate possible name change. This Shared Savings Program reference will not be included in a Choice COC.]

[[Shared Savings Program] - the [Shared Savings Program] provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the [Shared Savings Program] to pay claims when doing so will lower Eligible Expenses. We do not credential the [Shared Savings Program] providers and the [Shared Savings Program] providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by [Shared Savings Program] providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the [Shared Savings 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 deductible.]

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* does not include [Mental Illness][mental illness] or substance use disorders, regardless of the cause or origin of the [Mental Illness][mental illness] or substance use disorder.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

[¹Applies when OB/GYN Physicians are considered Primary Physicians.]

[²Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services and all clinicians are considered specialists.]

[³Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services and only clinicians that perform psychological testing are considered specialists.]

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, [¹obstetrics/gynecology,] family practice or general medicine. [²For [Mental Health Services] [and] [Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Specialist Physician.] [³For [Mental Health Services] [and] [Substance Use Disorder

Services], a licensed clinician who provides psychological testing is considered on the same basis as a Specialist Physician.]

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

[Applies when plan design includes benefits for substance use disorder services.]

[Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.]

[Applies when group purchases extended coverage for total disability.]

[Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.]

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Transitional Care - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

[Applies when plan design includes benefits for mental health services or neurobiological disorder/autism spectrum disorder services, but not substance use disorder services.]

[Transitional Care - Mental Health Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are supervised living arrangements which are residences that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence

available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.
- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
 - If the service is one that requires review by the *U.S. Food and Drug Administration (FDA)*, it must be *FDA*-approved.
 - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
 - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
 - At least two studies from more than one institution must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
 - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Group Policy

UnitedHealthcare Insurance Company

[185 Asylum Street]

[Hartford, Connecticut 06103-3408]

[1-800-357-1371]

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

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

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

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

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

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

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

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

This Policy is issued as described in Exhibit 1.

Issued By:

[UnitedHealthcare Insurance Company](#)

[Signature of authorized company officer]

[Title of authorized company officer]

Article 1: Glossary of Defined Terms

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

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

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

Article 2: Benefits

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

Article 3: Premium Rates and Policy Charge

3.1 Premiums

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

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

3.2 Computation of Policy Charge

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

3.3 Adjustments to the Policy Charge

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

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

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

Grace Period is mandatory in Arkansas

3.4 Payment of the Policy Charge

[Variable provisions apply when advance payment is supported in Exhibit 1.]

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

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

¹Include when grace period provision applies.]

²Include when grace period provision does not apply.]

A late payment charge will be assessed for any Policy Charge not received [\[¹within \[10 - 45\] calendar days following the due date.\]](#) [\[²by the due date.\]](#) A service charge will be assessed for any non-sufficient-fund check received in payment of the Policy Charge. All Policy Charge payments must be accompanied by supporting documentation that states the names of the Covered Persons for whom payment is being made.

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

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

3.5 Grace Period

A grace period of [\[¹31 - 90\] days](#) will be granted for the payment [\[of any Policy Charge not paid when due.](#) During the grace period, this Policy will continue in force. The grace period will not extend beyond the date this Policy terminates.

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

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

Article 4: Eligibility and Enrollment

4.1 Eligibility Conditions or Rules

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

4.2 Initial Enrollment Period

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

[\[4.3\] \[Open Enrollment Period\]](#)

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

[4.4] Effective Date of Coverage

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

Article 5: Policy Termination

5.1 Conditions for Termination of the Entire Policy

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

^[1] Include when grace period applies and coverage terminates on the last day of the grace period.]

^[2] Include when grace period does not apply and coverage terminates on the last paid date.]

^[3] Include when grace period applies and coverage terminates on the last paid date.]

- A. ^[1]On the last day of the grace period if the Policy Charge remains unpaid. The Enrolling Group remains liable for payment of the Policy Charge for the period of time this Policy remained in force during the grace period.] ^[2]At our option, retroactive to the last paid date of coverage if the Policy Charge remains unpaid on the due date.] ^[3]At our option, retroactive to the last paid date of coverage if the grace period expires and the Policy Charge remains unpaid on the due date.]
- B. On the date specified by the Enrolling Group, after at least 31 days prior written notice to us that this Policy is to be terminated.

[Include when either contribution or participation rules apply.]

- [C.] [On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated due to the Enrolling Group's violation of the [participation] [and][or] [contribution] rule[s] as shown in Exhibit 1.]
- [D]. On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated because the Enrolling Group performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Policy or to the provision of coverage under this Policy. In this case, we have the right to rescind this Policy back to either:
- The effective date of this Policy.
 - The date of the act, practice or omission, if later.
- [E]. On the date we specify, after at least 90 days prior written notice to the Enrolling Group, that this Policy is to be terminated because we will no longer issue this particular type of group health benefit plan within the applicable market.
- [F]. On the date we specify, after at least 180 days prior written notice to the applicable state authority and to the Enrolling Group, that this Policy is to be terminated because we will no longer issue any employer health benefit plan within the applicable market.

5.2 Payment and Reimbursement Upon Termination

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

Article 6: General Provisions

6.1 Entire Policy

This Policy, including the *Certificate(s) of Coverage*, the *Schedule(s) of Benefits*, the application of the Enrolling Group, and any Amendments, Notices of Change, and Riders, constitute the entire Policy

between the parties. All statements made by the Enrolling Group or by a Subscriber will, in the absence of fraud, be deemed representations and not warranties.

6.2 Dispute Resolution

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

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

Arbitration will take place in [\[Hartford County, Connecticut\]](#).

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

6.3 Time Limit on Certain Defenses

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

6.4 Amendments and Alterations

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

6.5 Relationship between Parties

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

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

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

6.6 Records

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

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

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

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

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

6.7 Administrative Services

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

We may offer to provide administrative services to the Enrolling Group for certain wellness programs including, but not limited to, fitness programs, biometric screening programs and wellness coaching programs.

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

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

[6.9] Examination of Covered Persons

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

[6.10] Clerical Error

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

[6.11] Workers' Compensation Not Affected

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

[6.12] Conformity with Law

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

[6.13] Notice

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

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

[6.14] Continuation Coverage

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

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

[6.15] Certification of Coverage Forms

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

[6.16] Subscriber's Individual Certificate

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

[6.17] System Access

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

System Access

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

The Enrolling Group will not:

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

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

Security Procedures

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

System Access Termination

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

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

Exhibit 1

1. **Parties.** The parties to this Policy are [UnitedHealthcare Insurance Company [of _____]] and _____, the Enrolling Group.
2. **Effective Date of this Policy.** The effective date of this Policy is 12:01 a.m. on [_____, 20__] in the time zone of the Enrolling Group's location.

^[1]ERISA groups.]

^[2]Non-ERISA groups.]

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

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

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

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

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

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

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

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

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

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

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

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

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

(Name of Issuing Entity)

(Address)

(City, State, Zip)

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

(Enrolling Group)

(Address)

(City, State, Zip)

[10]. [____ Enrolling Group Number]

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

Exhibit 2 [¹Class [1-10]]

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

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

1. **Class Description.**

[All full-time employees.][See Application.]

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

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

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

[_____]

B. Other:

[_____]

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

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

For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is [the day following the last day of the required waiting period.] [the first day of the month following the last day of the required waiting period.] [the date the Eligible Person joins the Enrolling Group.] [the first day of the month following the date the Eligible Person joins the Enrolling Group.][as determined by the Enrolling Group, _____]. Any required waiting period will not exceed 90 days.

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

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

Coverage Classification	Monthly Premium
Subscriber only	\$XXX.XX
Subscriber and spouse	\$XXX.XX
Subscriber plus one child	\$XXX.XX
Subscriber plus family	\$XXX.XX]

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

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

[Monthly Premiums payable by or on behalf of Covered Persons are specified in the *Cost Summary* detailed through the new business premium confirmation process and renewal package.]

[Exhibit 3 - Miscellaneous Provisions]

[¹Applies to Simply Engaged 3.0.]

[Exhibit [#] - [SimplyEngaged[®] [¹Plus]]

[¹The Enrolling Group agrees it will only offer its employees a full-replacement, *UnitedHealthcare DefinitySM Consumer-Driven Health* plan or a *High Deductible Health* plan. The Enrolling Group will make commercially reasonable efforts to design an attractive plan and communicate the plan effectively.

[Include when program is offered to dependent spouses.]

The Enrolling Group agrees it will promote a wellness program that rewards Subscribers [and Enrolled Dependent spouses] for meeting the following biometric targets:]

Table applies to Simply Engaged 3.0.

[Biometric Measure]	[Target]
[Cholesterol (Total)]	[<[X] MG]
[Blood Pressure]	[<[X/X]]
[BMI]	[<[X] KG]
[Nicotine]	[None]
[Others_____]	[Others_____]
[The program will provide a reasonable alternative standard to qualify for the incentive to any individual for whom it is unreasonably difficult due to a medical condition or medically inadvisable to meet a specified target.]	

[¹Applies to Simply Engaged 2.0.]

[²Include when program is offered to dependent spouses.]

[³Applies to Simply Engaged 3.0.]

[¹The Enrolling Group agrees it will promote a wellness program that rewards Subscribers [²and Enrolled Dependent spouses] for completing certain wellness activities.] Incentives [³also] can be earned by completing [the *Health Assessment*] [,] [and] [*Online Coaching*] [,] [and] [*Telephonic Wellness Coaching*] [,] [and] [*Other*_____]. [³Incentives based on meeting certain biometric targets are outcome-based incentives and are only available to Subscribers [²and Enrolled Dependent spouses].] These incentives are activity-based incentives and are available to Subscribers [²and Enrolled Dependent spouses]. [³The Enrolling Group will be responsible for funding all incentives, including but not limited to, outcome-based incentives and activity-based incentives.]

The Enrolling Group agrees it will establish a simple but formal “workplace wellness program” and implement at least the following three easy program components:

- An announcement letter sent to all the Enrolling Group's employees from the Enrolling Group's owner or a senior executive, promoting the incentive program.
- Sponsor at least one health fair/wellness event within the first [X] days of the Policy year (including a biometric screening), making commercially reasonable effort to have at least [X]% attendance. The biometric screening event must be held the same day as the health/wellness event during standard hours for screening events, which are Monday through Friday, 5:00 a.m. to 7:00 p.m., EST.
- Send out a quarterly communication (newsletter, article or flyer) on a health and wellness topic to Enrolling Group's employees.

The Enrolling Group agrees it will meet formally two times per year with its broker and our representative. These meetings will be with the Enrolling Group's owner or a senior executive of the Enrolling Group. The first meeting must occur early in the Policy year to address the details of implementing the Enrolling Group's obligation as described in this Exhibit. The second meeting must occur at least [X] days prior to the anniversary date of the Policy.

¹Applies to Simply Engaged 3.0.]

²Applies to Simply Engaged 2.0.]

³Include when program is offered to dependent spouses.]

¹The Enrolling Group agrees that it is responsible for funding the amounts for incentives earned by its Subscribers ³and Enrolled Dependent spouses] for both activity-based and outcome-based incentive awards.] The incentive amounts earned will be ¹credited by the Enrolling Group to either a *Health Reimbursement Account* or a *Health Savings Account* administered by us] ²issued in the form of gift cards] [Other].

We will administer activity based and outcome based incentives for Enrolling Group's Subscribers ³and Enrolled Dependent spouses] as described herein. Enrolling Group acknowledges incentives can only be earned by Subscribers ³and Enrolled Dependent spouses] once every 365 days. For example, if a *Health Assessment* is completed on January 1, 2010 and the Subscriber ³or Enrolled Dependent spouse] receives a \$75 incentive, the Subscriber ³or Enrolled Dependent spouse] will not become eligible to earn an additional incentive for completion of a new *Health Assessment* until January 1, 2011.

After receiving at least 60 days prior written notice for event implementing, we will cover the cost of a single biometric screening, per event, per year, for each Subscriber participating in such screenings at the Enrolling Group's fair/wellness event. If less than [X] individuals participate in such biometric screening, we may impose an additional fee on Enrolling Group.

Exhibit [#]

[Incentives for Health]

[¹Applies when plan includes spouses.]

The Enrolling Group agrees to offer an incentive plan to Eligible Persons. The Enrolling Group agrees to offer the incentive plan in subsequent Policy years if Subscribers [¹and Enrolled Dependent spouses] meet the requirements outlined in the [Incentives for Health] Rider. The Enrolling Group will make commercially reasonable efforts to promote and communicate the plan effectively.

[Include when program is outcome-based.]

[The plan will provide a reasonable alternative standard to qualify for the incentive plan to any individual for whom it is unreasonably difficult to meet a specified target, due to a medical condition or medically inadvisable reason.]

The Enrolling Group agrees to offer a base plan to Subscribers [¹and Enrolled Dependent spouses] who do not meet the requirements outlined in the [Incentives for Health] Rider.

[The Enrolling Group agrees to charge Subscribers the same contribution amount for the base plan and the incentive plan.]

The Enrolling Group agrees to administer eligibility in accordance with the requirements set forth in the [Incentives for Health] Rider.

We will determine which Subscribers [¹and Enrolled Dependent spouses] meet the requirements set forth in the [Incentives for Health] Rider.

Exhibit [#]

[Name of Wellness Plan]

[¹Applies when plan includes spouses.]

The Enrolling Group agrees to offer a base plan to Eligible Persons. In addition, the Enrolling Group agrees to offer an incentive plan in subsequent Policy years if Subscribers [¹and Enrolled Dependent spouses] meet the requirements outlined in the [Name of Wellness Plan] Rider. The Enrolling Group will make commercially reasonable efforts to promote and communicate the plan effectively.

[The Enrolling Group agrees to charge Subscribers the same contribution amount for the base plan and the incentive plan.]

[Include when program is outcome-based.]

[The plan will provide a reasonable alternative standard to qualify for the incentive plan to any individual for whom it is unreasonably difficult to meet a specified target, due to a medical condition or medically inadvisable reason.]

The Enrolling Group agrees to administer eligibility in accordance with the requirements set forth in the [Name of Wellness Plan] Rider.

We will determine which Subscribers [¹and Enrolled Dependent spouses] meet the requirements set forth in the [Name of Wellness Plan] Rider.

[This Schedule of Benefits supports both ¹Choice Plus and ²Core products.]

UnitedHealthcare [¹Choice Plus] [²Core]

[UnitedHealthcare Insurance Company]

Schedule of Benefits

Accessing Benefits

[Include for the Core product.]

[UnitedHealthcare Core offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a UnitedHealthcare Core Network provider. You can confirm that your provider is a UnitedHealthcare Core Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com].]

[Designated network benefits are variable for several benefit categories. Include references throughout the schedule as needed when designated network benefits are available for any category.]

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

[Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that we have identified as a Designated Facility or Physician. Designated Network Benefits are available only for specific Covered Health Services as identified in the *Schedule of Benefits* table below.]

[Include if non-network RAPLs at a network facility are paid as network benefits.]

[Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.]

[Include when non-network RAPLs and consultants at a network facility are paid as network benefits and when non-emergent network benefits for these services provided by non-network providers will not be paid at billed charges.]

[Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. Network Benefits also apply to Covered Health Services that are provided at a Network facility by a non-Network [radiologist] [,] [or] [anesthesiologist] [,] [or] [pathologist] [,] [or] [consulting Physician] [,] [or] [neonatologist] [,] [or] [intensivist] [,] [or] [assistant surgeon] [or] [surgical assistant], however such Covered Health Services, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. As a result you will be responsible for the difference between the amount billed by the provider and the amount we determine to be an Eligible Expense for reimbursement.]

[Include when non-network RAPLs and consultants at a network facility are paid as non-network benefits.]

[Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility. Emergency Health Services are always paid as Network Benefits.]

[Include when non-network RAPLs and consultants at either a network or non-network facility are paid as non-network benefits.]

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. [Covered Health Services, when not Emergency Health Services, provided in a Network facility by a non-Network [radiologist] [,] [or] [anesthesiologist] [,] [or] [pathologist] [,] [or] [consulting Physician] [,] [or] [neonatologist] [,] [or] [intensivist] [,] [or] [assistant surgeon] [or] [surgical assistant] will be paid as Non-Network Benefits.]

[Include when the enhanced benefits program is sold.]

[You may have an opportunity to elect to receive Covered Health Services from certain Network providers that we've identified as Designated Physicians or Designated Facilities. When you choose to seek care from certain Designated providers, the level of Benefits available to you is enhanced. You can determine the specific situations for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[¹Include when shared savings program applies.]

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

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a [UnitedHealthcare] Policy. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

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

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

To obtain prior authorization, call the telephone number for *Customer Care* on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to determine how far in advance you must obtain prior authorization.

[Include bracketed variable benefit category listed below if: a) the benefit is included in the plan design and b) prior authorization is required. Include dollar amounts as applicable.]

- [_____]
- Ambulance - non-emergent air and ground.
- Clinical trials.
- [Congenital heart disease surgery.]
- [Dental services - accidental.]
- Dental services - anesthesia and hospitalization and ambulatory surgery.
- [Diabetes equipment - insulin pumps [over \$[1,000 - 5,000]].]
- [Durable Medical Equipment [over \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)].]
- [Medical Foods.]

[Include when prior authorization is required for only BRCA genetic testing.]

- [Genetic Testing - BRCA.]

[Include when prior authorization is required for all genetic testing.]

- [Genetic Testing, including BRCA Genetic Testing.]
- [Hearing aids [that exceed \$[1,000 - 5,000] in retail purchase cost].]
- [Home health care.]
- [Hospice care - inpatient.]
- Hospital inpatient care - all scheduled admissions [and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery].
- [Infertility services.]
- In vitro fertilization services.
- [Lab, X-ray and diagnostics - sleep studies.]
- [Lab, X-ray and major diagnostics - CT, PET Scans, MRI, MRA, Nuclear Medicine and Capsule Endoscopy.]

[Include when group purchases benefits for musculoskeletal disorders.]

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

- [Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.]
- [Neurobiological disorders - Autism Spectrum Disorder services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management[; Applied Behavioral Analysis (ABA)].]
- [Obesity surgery.]

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

- Orthotics devices [¹over\$[1,000-5,000]].
- [Pain management.]
- [Pharmaceutical Products - IV infusions only.]
- [Certain Pharmaceutical Products. You may determine whether a particular Pharmaceutical Product requires authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

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

- Prosthetic devices [1over \$[1,000 - 5,000]].]
- Reconstructive procedures, including breast reconstruction surgery following mastectomy [and breast reduction surgery].
- [Rehabilitation services [and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy].]
- [Scopic procedures - outpatient diagnostic and therapeutic.]
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- [Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.]

[¹ Do not include pain management procedures if prior authorization is required for all pain management services above.]

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [¹pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgeries]].]
- [Temporomandibular joint services.]
- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound]].]

- Transplants.
- [Ventricular assist device implantation. You must obtain prior authorization as soon as the possibility of implantation arises except in cases of Emergency implantations of partial assist devices.]

[Include paragraph below if plan includes ability to determine alternate levels of benefits.]

[Here and throughout the document, include defined capitalized term if Mental Health Benefits are sold; include lower case reference if Mental Health Benefits are not sold.]

[As we determine, if one or more alternative health services that meets the definition of a Covered Health Service in the *Certificate* under *Section 9: Defined Terms* are clinically appropriate and not more costly than an alternative health service that is at least as likely to produce equivalent therapeutic or diagnostic results as to their prevention, diagnosis or treatment of a Sickness, Injury, [Mental Illness,] [mental illness,] substance use disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on *Generally Accepted Standards of Medical Practice*, which for some Covered Health Services may be addressed in our clinical policies. After you contact us for prior authorization, we will identify the Benefit level available to you.

These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.]

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

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.

[The Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

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

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

Payment Term And Description	Amounts
Annual Deductible	
<p><i>[Annual deductible is plan design variable. Include applicable provisions to support the following:</i></p> <p>¹Annual deductible applies only to non-network benefits.</p> <p>²Outpatient Prescription Drug Rider is sold and the annual deductible applies to any combination of medical and RX benefits.</p> <p>³Outpatient Prescription Drug Rider with separate copayments for preventive medications is sold and the annual deductible does not apply to preventive medications.</p> <p>⁴Outpatient Prescription Drug Rider is sold and when the annual deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the annual deductible.</p> <p>⁵There is a deductible for designated and network benefits and the network and non-network amounts apply to the designated network and network annual deductible.</p> <p>⁶Designated network benefits apply to any category.]</p> <p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive [¹Non-Network] Benefits. [²The Annual Deductible applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>. [³Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [⁴Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the <i>Outpatient Prescription Drug Rider</i> are not subject to payment of the Annual Deductible.] [⁵The Annual Deductible for [⁶Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drugs provided under the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include applicable provisions to support the following:</i></p> <p>¹Day/visit limits are reduced by the number of days/visit used toward meeting the deductible.</p> <p>²Carry-over provision applies.</p> <p>³Roll-over provision applies in any circumstance.</p> <p>⁴Roll-over provision applies only to groups changing from calendar to policy year. ⁵Include when roll-over applies only to the individual deductible.</p> <p>⁶Include only when a per occurrence deductible applies.]</p> <p>[¹Amounts paid toward the Annual Deductible for Covered</p>	<p>¹Include separate network and non-network headings and statements when annual deductible provision applies separately.]</p> <p>²Include when designated network benefits apply to any category and when the designated network and network deductible is combined.]</p> <p>³Include when designated network and network are separate.]</p> <p>[¹ [² Designated Network and] Network] [³ Designated Network]</p> <p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</p> <p>[No Annual Deductible.]</p> <p>[³ Network]</p> <p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered</p>

Payment Term And Description	Amounts
<p>Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.]</p> <p>[²Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.]</p> <p>[³When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.]</p> <p>[⁴When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [⁵This roll-over feature applies only to the individual Annual Deductible.]]</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>[⁶The Annual Deductible does not include any applicable Per Occurrence Deductible.]</p>	<p>Persons in a family.]</p> <p>[No Annual Deductible.]</p> <p>[¹ Non-Network]</p> <p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</p> <p>[No Annual Deductible.]</p> <p><i>⁴Include the combined network and non-network heading and statements when annual deductible provision applies separately to combined network and non-network benefits.</i></p> <p><i>⁵Include when designated network benefits apply to any category.]</i></p> <p>[⁴ ⁵ Designated Network,] Network and Non-Network]</p> <p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</p>
<p><i>[Per occurrence deductible is plan design variable.]</i></p>	

Payment Term And Description	Amounts
<p>[Per Occurrence Deductible]</p>	
<p>[The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services.</p> <p>You are responsible for paying the lesser of the following:</p> <ul style="list-style-type: none"> • The applicable Per Occurrence Deductible. • The Eligible Expense.] 	<p>[When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.]</p>
<p>Out-of-Pocket Maximum</p>	
<p><i>[Out-of-pocket maximum is plan design variable. Include applicable provisions to support the following:</i></p> <p>¹<i>Includes the annual deductible.</i></p> <p>²<i>Includes the per occurrence deductible.</i></p> <p>³<i>Includes copayments.</i></p> <p>⁴<i>Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.</i></p> <p>⁵<i>OOPM applies to designated and network benefits and the network and non-network amounts paid under the RX rider apply to the designated network and the network OOPM.</i></p> <p>⁶<i>Include bracketed designated network reference when designated network benefits apply to any category.]</i></p> <p>The maximum you pay per year for [¹the Annual Deductible,] [²the Per Occurrence Deductible,] [³Copayments] [¹⁻²⁻³or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [⁴The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.] [⁵The Out-of-Pocket Maximum for [⁶Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when plan design does not apply all copayments/coinsurance to the OOPM.]</i></p> <p>[[Copayments] [and] [Coinsurance] for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Maximum does not include any of the</p>	<p>¹<i>Include separate network and non-network headings and statements when OOPM provision applies separately.]</i></p> <p>²<i>Include when designated network benefits apply to any category and when the designated network and network OOPM is combined.]</i></p> <p>³<i>Include when designated network and network are separate.]</i></p> <p>[¹ [² Designated Network and] Network] [³ Designated Network]</p> <p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p>

Payment Term And Description	Amounts
<p>following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> Any charges for non-Covered Health Services. <p><i>[Include bullet if prior authorization requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.]</i></p> <ul style="list-style-type: none"> [The amount Benefits are reduced if you do not obtain prior authorization as required.] Charges that exceed Eligible Expenses. Copayments or Coinsurance for any Covered Health Service identified in the <i>Schedule of Benefits</i> table that does not apply to the Out-of-Pocket Maximum. <p><i>[Include when an Outpatient Prescription Drug Rider is sold and copayments/coinsurance do not apply to the overall OOPM.]</i></p> <ul style="list-style-type: none"> [Copayments or Coinsurance for Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.] 	<p>[No Out-of-Pocket Maximum.]</p> <p>⁸ Network</p> <p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p> <p>[No Out-of-Pocket Maximum.]</p> <p>¹ Non-Network</p> <p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum includes</p>

Payment Term And Description	Amounts
	<p>the Per Occurrence Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p> <p>[No Out-of-Pocket Maximum.]</p> <p>⁴Include combined network and non-network heading and statements below when OOPM provision applies to combined network and non-network benefits and delete the separate "Network" and "Non-Network" provisions above.]</p> <p>⁵Include when designated network benefits apply to any category.]</p> <p>[⁴ ⁵ Designated Network,] Network and Non-Network]</p> <p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p> <p>[No Out-of-Pocket Maximum.]</p>
<p>[Annual maximum benefit is plan design variable. Include applicable provisions to support the following:</p> <p>¹Outpatient Prescription Drug Rider is sold.]</p> <p>[Annual Maximum Benefit]</p>	

Payment Term And Description	Amounts
<p>[The maximum amount we will pay for Benefits during the year.] [¹The Annual Maximum Benefit applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.]</p>	<p>¹ <i>Include separate network and non-network headings and statements when the annual maximum benefit applies separately.</i></p> <p>² <i>Include when designated network benefits apply to any category and when the designated network and network maximum is combined.</i></p> <p>³ <i>Include when designated network and network are separate.</i></p> <p>⁴ <i>Include when combined network and non-network maximums apply.</i></p> <p>[¹ ² Designated Network and Network] [³ Designated Network]</p> <p>[\$[2,000 - 2,500,000] per Covered Person.]</p> <p>[No Annual Maximum Benefit.]</p> <p>[³ Network]</p> <p>[\$[2,000 - 2,500,000] per Covered Person.]</p> <p>[No Annual Maximum Benefit.]</p> <p>[¹ Non-Network]</p> <p>[\$[2,000 - 2,500,000] per Covered Person.]</p> <p>[No Annual Maximum Benefit.]</p> <p>[⁴ ² Designated Network,] Network and Non-Network]</p> <p>[\$[2,000 - 2,500,000] per Covered Person.]</p>
<p>Copayment</p>	
<p>Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.</p> <p>[For Pharmaceutical Products, your Copayments are determined by the tier to which the Pharmaceutical Product List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]</p> <p>Please note that for Covered Health Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> • The applicable Copayment. • The Eligible Expense. <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	

Payment Term And Description	Amounts
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.	
[For Pharmaceutical Products, your Coinsurance is determined by the tier to which the Pharmaceutical Product List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]	
Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.	

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design.]

[Include the following variables according to plan design:

- Benefit limits and levels.*
- Prior authorization requirements and any penalty for failure to prior authorize*
- Designated network benefit levels as applicable.*
- Any other specific conditions for coverage described within the category.]*

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
1. [Acupuncture Services]			
[Limited to [10 - 100] treatments per year.]	[Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[Limited to [10 - 100] treatments per year, not to exceed \$[100 - 5,000] in Eligible Expenses per year.]	[100% after you pay a Copayment of \$[5 - 75] per visit]	[Yes, when Benefits are subject to Coinsurance]	[Yes, when Benefits are subject to Coinsurance]
[Limited to \$[100 - 5,000] in Eligible Expenses per year.]	[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]		[Yes, after the Per Occurrence Deductible of \$[5 - 75] per visit is satisfied]
[This limit applies to Network Benefits only. Non-Network Benefits are not available.]	[Non-Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of \$[5 - 75] per visit]	[Yes, when Benefits are subject to	[Yes, when Benefits are subject to

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Non-Emergency Ambulance</p> <p>Ground or air ambulance, as we determine appropriate.</p>	<p>[100% after you pay a Copayment of \$[2,500 - 10,000] per day, up to a per day maximum of \$[2,500 - 10,000]]</p> <p>Non-Network</p> <p>Same as Network</p> <p>Network</p> <p><i>Ground Ambulance:</i></p> <p>[[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[25 - 300] per transport]</p> <p>[100% after you pay a Copayment of \$[300 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[300 - 1,000] per day, up to a per day maximum of \$[300 - 1,000]]</p> <p><i>Air Ambulance:</i></p> <p>[[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[25 - 2,500] per transport]</p> <p>[100% after you pay a Copayment of \$[2,500 - 10,000] per day]</p> <p>[100% after you pay a Copayment of \$[2,500 - 10,000] per day, up to a per day maximum of \$[2,500 - 10,000]]</p> <p>Non-Network</p> <p>Same as Network</p>	<p>Same as Network</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>Same as</p>	<p>Same as Network</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 1,000] per [transport] [day] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 10,000] per [transport] [day] is satisfied]</p> <p>Same as Network</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
		Network	
[3.] Clinical Trials			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
<p>Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i>.</p> <p>Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)</p>	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
[4.] [Congenital Heart Disease Surgeries]			
<p style="text-align: center;">[Prior Authorization Requirement]</p> <p>[For Designated Network Benefits you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you do not obtain prior authorization and if, as a result, the CHD services are not performed at a Designated Facility, Designated Network Benefits will not be paid.] [Non-Network Benefits will apply.]</p> <p>[For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
<p>[Designated Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac</p>	<p>[Designated Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[100 -</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i></p> <p>[Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i></p> <p>[For Network Benefits, CHD surgeries must be received at a Designated Facility.</p> <p>Non-Network Benefits include services provided at a Network facility that is not a Designated Facility and services provided at a non-Network facility.</p> <p>Non-Network Benefits under this section include only the CHD surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i></p>	<p>1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p>[Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p>[Non-Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 -</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[day] [Inpatient Stay] is satisfied]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	2,000] per Inpatient Stay] [100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]		Stay] is satisfied]
[5.] [Dental Services - Accident Only]			
[Prior Authorization Requirement]			
[For Network and Non-Network Benefits you must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Limited to \$[2,000 - 5,000] per year. Benefits are further limited to a maximum of \$[500 - 1,500] per tooth.]	[Network] [[50 - 100]%] [100% after you pay a Copayment of \$[5 - 75] per visit] [Non-Network] [Same as Network]	[Yes] [No] [Same as Network]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 75] per visit is satisfied] [Same as Network]
[6.] Diabetes Services			
^[1] Include when the durable medical equipment benefit is sold.]			
^[2] Include when the durable medical equipment benefit is not sold.]			
Prior Authorization Requirement			
For Non-Network Benefits you must obtain prior authorization before obtaining any ^[1] Durable Medical Equipment] ^[2] diabetes equipment] for the management and treatment of diabetes [that exceeds \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].			
Diabetes Self-Management and	Network		

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>[For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p>Non-Network</p> <p><i>[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]</i></p> <p>[Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]</i></p> <p>[For diabetes equipment, Benefits will be the same as those stated under <i>Durable Medical Equipment</i>.</p> <p>For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p><i>[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]</p> <p>Benefits for diabetes supplies will be the same as those stated in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p>		
[7.] [Durable Medical Equipment]			

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment [that exceeds \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>[Limited to \$[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two - five] years]. [This limit does not apply to wound vacuums[, which are subject to a separate limit of \$[4,500 - 13,500] per year and limited to a single purchase (including repair/replacement) every [year] [[two - five] years]].]</p> <p>[Limited per year as follows:</p> <ul style="list-style-type: none"> • [\$[500 - 10,000] in Eligible Expenses for Tier 1. Tier 1 includes disposable supplies necessary for the effective use of covered Durable Medical Equipment.] • [\$[10,001 - 25,000] in Eligible Expenses for Tier 2.] • [\$[25,001 - 100,000] in Eligible Expenses for Tier 3.] <p>These Tier limits include repair. Benefits for replacement are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].]</p> <p>[Benefits are [further] limited to a single Mobility Device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair of the Mobility Device are limited to once every three years. We may, upon review, replace a defective Mobility Device rather than repair it. Benefits are not available for repair or</p>	<p>[Network]</p> <p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 500] per purchase is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>replacement of a Mobility Device resulting from abuse, neglect or normal wear.]</p> <p>[Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every three years. Speech aid and tracheo-esophageal voice devices are [not] included in the annual limits stated above.]</p> <p>[To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.]</p>	<p>[Non-Network]</p> <p>[[50 - 100]%</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 500] per purchase is satisfied]</p> <p>[Non-Network Benefits are not available.]</p>
<p>[8.] Emergency Health Services - Outpatient</p>			
<p>Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.</p>	<p>Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit. [If you are admitted as an inpatient to a Network Hospital [directly from the Emergency room] [within 24 hours of receiving outpatient Emergency treatment for the same condition], you will not have to pay this</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 700] per visit is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed as an Emergency Health Service:</p> <ul style="list-style-type: none"> • [Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient.</i>] • [Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.</i>] • [Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient.</i>] • [Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>] • [Outpatient surgery procedures described under <i>Surgery - Outpatient.</i>] • [Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i>] • [Rehabilitation therapy procedures described under <i>Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment].</i>] 	<p>Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.]]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; 100% after you pay a Copayment of \$[50 - 650] for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; 100% after you pay a Copayment of \$[50 - 650] per visit for the next [#] visits in a year; 100% after you pay a Copayment of \$[100 - 700] for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year;</p>		

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>100% after you pay a Copayment of \$[50 - 650] per visit for the next [#] visits in a year; 100% after you pay a Copayment of \$[100 - 500] for the next [#] visits in a year; 100% after you pay a Copayment of \$[150 - 700] for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for a condition defined as an Emergency; 100% after you pay a Copayment of \$[50 - 650] per visit for a condition that does not meet the definition of an Emergency]</p> <p>Non-Network Same as Network</p>	Same as Network	Same as Network
<p><i>Include as standard for groups of 2 to 15 and 15+.</i></p> <p>[9.] Hearing Aids</p>	<p align="center">[Prior Authorization Requirement]</p> <p align="center">[For Non-Network Benefits you must obtain prior authorization before obtaining a hearing aid [that exceeds \$[1,000 - 5,000] in retail purchase cost]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>		
<p>Limited to \$[2,800 - 5,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[three-five] years].]</p>	<p>[Network] [[50 - 100]%]</p>	[Yes] [No]	<p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[50</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Copayment of \$[5 - 50] per visit]		Occurrence Deductible of \$[5 - 50] per visit is satisfied]
[11.] Hospice Care			
<p align="center">[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p>[In addition, for Non-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]</p>			
	<p>Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per day]</p> <p>Non-Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per day]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per day is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per day is satisfied]</p>
[12.] Hospital - Inpatient Stay			
<p align="center">Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>			

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[When you choose to seek care from Designated Network facilities for certain surgical procedures [or as a result of certain diagnoses], your Benefits will be enhanced as described below:]</p> <ul style="list-style-type: none"> [The Copayment you pay for the facility charge [and Physician's fees] for services provided at a Designated Network facility will be reduced to \$[0 - 1,000]. [The maximum reduction in Copayments is \$[10 - 1,000].] [The Coinsurance you pay for the facility charge [and Physician's fees] for services provided at a Designated Network facility will be reduced to [0 - 50]% or \$[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of \$[10 - 1,000].] <p>[You can determine the specific surgical procedures or diagnoses for</p>	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 10,000] per Inpatient Stay]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 10,000] per Inpatient Stay]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>which enhanced Benefits are available by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p> <p>[[For Network Benefits, ventricular] [Ventricular] assist device implantation services must be received at a Designated Facility.]</p> <p>[Non-Network Benefits for ventricular assist device implantation are limited to \$[30,000 - 250,000] per implantation.]</p>	<p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 10,000] per Inpatient Stay]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>
<p>[13]. [Infertility Services]</p>			
<p align="center">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>[Limited to \$[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for</p>	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[Network]</p> <p>[[50 - 100]%]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>coverage under the Policy. [This limit includes Benefits for infertility medications provided under the <i>Outpatient Prescription Drug Rider</i>.] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under <i>Physician's Office Services - Sickness and Injury</i> below.]</p>	<p>[Non-Network]</p> <p>[[50 - 100]%]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>
<p>[14.] Lab, X-Ray and Diagnostics - Outpatient</p>			
<p align="center">[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits for sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>Lab Testing - Outpatient:</p>	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at a free-standing lab]</p> <p>[[50 - 100]% at a Hospital-based lab]</p> <p>[[50 - 100]% at a Physician office-based lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a free-standing lab]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>[100% after you pay a Copayment of \$[5 - 100] per service at a Hospital-based lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a Physician office-based lab]</p> <p>Network</p> <p>[[50 - 100]%</p> <p>[[50 - 100]% at a free-standing lab]</p> <p>[[50 - 100]% at a Hospital-based lab]</p> <p>[[50 - 100]% at a Physician office-based lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a free-standing lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a Hospital-based lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a Physician office-based lab]</p> <p>Non-Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 -</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Non-Network Benefits are not</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 -</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>X-Ray and Other Diagnostic Testing - Outpatient:</p>	<p>100] per service] [Non-Network Benefits are not available.]</p> <p>[Designated Network]</p> <p>[[50 - 100]% [[50 - 100]% at a free-standing diagnostic center] [[50 - 100]% at an outpatient Hospital-based diagnostic center]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service] [100% after you pay a Copayment of \$[5 - 100] per service at a free-standing diagnostic center] [100% after you pay a Copayment of \$[5 - 100] per service at an outpatient Hospital-based diagnostic center]</p> <p>Network</p> <p>[[50 - 100]% [[50 - 100]% at a free-standing diagnostic center] [[50 - 100]% at an outpatient Hospital-based diagnostic center] [100% after you pay a</p>	<p>available.]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>100] per service is satisfied] [Non-Network Benefits are not available.]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Copayment of \$[5 - 100] per service]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a free-standing diagnostic center]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at an outpatient Hospital-based diagnostic center]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Non-Network Benefits are not available.]</p>
<p>[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</p>			
<p align="center">[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at a free-standing diagnostic center]</p> <p>[[50 - 100]% at an</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 500] per service is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>outpatient Hospital-based diagnostic center]</p> <p>[100% after you pay a Copayment of \$[25 - 500] per service]</p> <p>[100% after you pay a Copayment of \$[25 - 500] per service at a free-standing diagnostic center]</p> <p>[100% after you pay a Copayment of \$[25 - 500] per service at an outpatient Hospital-based diagnostic center]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at a free-standing diagnostic center]</p> <p>[[50 - 100]% at an outpatient Hospital-based diagnostic center]</p> <p>[100% after you pay a Copayment of \$[25 - 500] per service]</p> <p>[100% after you pay a Copayment of \$[25 - 500] per service at a free-standing diagnostic center]</p> <p>[100% after you pay a Copayment of \$[25 - 500] per service at an outpatient Hospital-based diagnostic center]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 500] per service is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Non-Network</p> <p>[[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[25 - 500] per service]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 500] per service is satisfied]</p> <p>[Non-Network Benefits are not available.]</p>
<p><i>Include for groups that purchase Mental Health benefits.</i></p> <p><i>[Include as standard for groups of 2 to 15]</i></p> <p>¹<i>Include if group purchases SA benefits.</i></p> <p>[16.] Mental Health Services</p>	<p align="center">[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95] % of Eligible Expenses.]</p>		
<p><i>[Limits will not apply to groups of 51+.]</i></p> <p>[Inpatient Mental Health Services are limited to [10 - 100] days per year.]</p> <p>[Outpatient Mental Health Services are limited to [10 - 100] visits per year.]</p> <p>[Non-Network Benefits for inpatient Mental Health Services are limited to [10 - 100] days per year.]</p>	<p>[Network]</p> <p><i>[Inpatient]</i></p> <p>[[50 - 100] %]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[Non-Network Benefits for outpatient <i>Mental Health Services</i> are limited to [10 - 100] visits per year.]</p> <p>[Benefits for any combination of <i>Mental Health Services</i> described in this section and <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i> described below are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Mental Health Services</i> and <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Mental Health Services</i> and <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>.] <p>[Benefits for any combination of <i>Mental Health Services</i> described in this section and <i>Substance Use Disorder Services</i> described below are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] 	<p>Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p><i>[Outpatient]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p> <p><i>[Non-Network]</i></p> <p><i>[Inpatient]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[Benefits for any combination of <i>Mental Health Services</i> described in this section and <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i> and <i>Substance Use Disorder Services</i> described below are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services, Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services, Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] 	<p>of \$[100 - 5,000] per Inpatient Stay</p> <p>[Outpatient]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>
<p>[17.] [Neurobiological Disorders - Autism Spectrum Disorder Services]</p>	<p>[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits for a scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management[; Applied Behavioral Analysis].</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>		
<p>[Limits will not apply to groups of 51+.]</p> <p>[Inpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i> are limited to [10 - 100] days per year.]</p> <p>[Outpatient <i>Neurobiological Disorders -</i></p>	<p>[Network]</p> <p>[Inpatient]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Autism Spectrum Disorder Services are limited to [10 - 100] visits per year.</i></p> <p><i>[Non-Network Benefits for inpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] days per year.]</i></p> <p><i>[Non-Network Benefits for outpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] visits per year.]</i></p> <p><i>[Benefits for any combination of Neurobiological Disorders - Autism Spectrum Disorder Services described in this section and Mental Health Services described above are limited as follows:</i></p> <ul style="list-style-type: none"> <i>• [10 - 100] days per year for inpatient Neurobiological Disorders - Autism Spectrum Disorder Services and Mental Health Services.</i> <i>• [10 - 100] visits per year for outpatient Neurobiological Disorders - Autism Spectrum Disorder Services and Mental Health Services.]</i> <p><i>[Benefits for any combination of Neurobiological Disorders - Autism Spectrum Disorder Services described in this section, Mental Health Services described above and Substance Use Disorder Services described further below are limited as follows:</i></p> <ul style="list-style-type: none"> <i>• [10 - 100] days per year for inpatient Neurobiological Disorders - Autism Spectrum</i> 	<p><i>Copayment of \$[100 - 1,000] per day]</i></p> <p><i>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</i></p> <p><i>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</i></p> <p><i>[Outpatient]</i></p> <p><i>[[50 - 100]%]</i></p> <p><i>[100% after you pay a Copayment of \$[5 - 100] per visit]</i></p> <p><i>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</i></p> <p><i>[100% for visits for medication management]</i></p> <p><i>[Non-Network]</i></p> <p><i>[Inpatient]</i></p> <p><i>[[50 - 100]%]</i></p> <p><i>[100% after you pay a Copayment of \$[100 - 1,000] per day]</i></p> <p><i>[100% after you pay a Copayment of \$[100 -</i></p>	<p></p> <p></p> <p></p> <p>[Yes] [No]</p> <p></p> <p></p> <p></p> <p>[Yes] [No]</p> <p></p> <p></p> <p></p> <p>[Yes] [No]</p>	<p><i>[\$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</i></p> <p></p> <p></p> <p>[Yes] [No]</p> <p><i>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</i></p> <p></p> <p></p> <p>[Yes] [No]</p> <p><i>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</i></p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Disorder Services, Mental Health Services and Substance Use Disorder Services.</i></p> <ul style="list-style-type: none"> <i>[10 - 100] visits per year for outpatient Neurobiological Disorders - Autism Spectrum Disorder Services, Mental Health Services and Substance Use Disorder Services.]</i> 	<p>2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p><i>[Outpatient]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>
<p>[18.] [Obesity Surgery]</p>	<p>[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p>[In addition, for Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.]</p> <p>[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]</p>		
<p>[[Any combination of] [Designated Network Benefits] [,.] [and] [Network Benefits] [and Non-Network] Benefits [is] [are] limited to \$[40,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy. [Non-Network Benefits are further limited to</p>	<p>[Designated Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p>		

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>\$[5,000 - 30,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]]</p> <p>[Non-Network Benefits include services provided at a Network facility that is not a Designated Facility and services provided at a non-Network facility.]</p>	<p>[Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p> <p>[Non-Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p> <p>[Non-Network Benefits are not available.]</p>		
<p>[19.] [Ostomy Supplies]</p>			
<p>[Limited to \$[500 - 25,000] per year.]</p>	<p>[Network]</p> <p>[[50 - 100]%]</p> <p>[Non-Network]</p> <p>[[50 - 100]%]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per item is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per item is satisfied]</p> <p>[Non-Network Benefits are not available.]</p>
<p>[20.] Pharmaceutical Products - Outpatient</p>			
<p align="center">[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits you must obtain prior authorization five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as</p>			

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p> <p>[For Non-Network Benefits you must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses. You may determine whether a particular Pharmaceutical Product requires prior authorization through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>			
<p>[The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Pharmaceutical Product, unless adjusted based on the manufacturer's packaging size, or based on supply limits. <p>When a Pharmaceutical Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.]</p>	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[0 - 75] per Tier 1 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[15 - 250] per Tier 2 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[20 - 450] per Tier 3 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[70 - 650] per Tier 4 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[100 - 750] per Tier 5 Pharmaceutical Product]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per Pharmaceutical Product is satisfied]</p> <p>[Yes, except when provided during a Physician office visit]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Product]</p> <p>[100% after you pay a Copayment of \$[150 - 850] per Tier 6 Pharmaceutical Product]</p> <p>[[50 - 100]% - Tier 1]</p> <p>[[50 - 100]% - Tier 2]</p> <p>[[50 - 100]% - Tier 3]</p> <p>[[50 - 100]% - Tier 4]</p> <p>[[50 - 100]% - Tier 5]</p> <p>[[50 - 100]% - Tier 6]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[0 - 75] per Tier 1 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[15 - 250] per Tier 2 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[20 - 450] per Tier 3 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[70 - 650] per Tier 4 Pharmaceutical</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per Pharmaceutical Product is satisfied]</p> <p>[Yes, except when provided during a Physician office visit]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Product]</p> <p>[100% after you pay a Copayment of \$[100 - 750] per Tier 5 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[150 - 850] per Tier 6 Pharmaceutical Product]</p> <p>[[50 - 100]% - Tier 1]</p> <p>[[50 - 100]% - Tier 2]</p> <p>[[50 - 100]% - Tier 3]</p> <p>[[50 - 100]% - Tier 4]</p> <p>[[50 - 100]% - Tier 5]</p> <p>[[50 - 100]% - Tier 6]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[0 - 75] per Tier 1 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[15 - 250] per Tier 2 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[20 - 450] per Tier 3 Pharmaceutical</p>	<p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per Pharmaceutical Product is satisfied]</p> <p>[Yes, except when provided during a Physician office visit]</p> <p>[Non-Network Benefits are not available.]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Product]</p> <p>[100% after you pay a Copayment of \$[70 - 650] per Tier 4 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[100 - 750] per Tier 5 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[150 - 850] per Tier 6 Pharmaceutical Product]</p> <p>[[50 - 100]% - Tier 1]</p> <p>[[50 - 100]% - Tier 2]</p> <p>[[50 - 100]% - Tier 3]</p> <p>[[50 - 100]% - Tier 4]</p> <p>[[50 - 100]% - Tier 5]</p> <p>[[50 - 100]% - Tier 6]</p> <p>[Non-Network Benefits are not available.]</p>		
<p>[21.] Physician Fees for Surgical and Medical Services</p>			
<p>[When you choose to seek care [as a result of certain diagnoses or] from Designated Network Physicians as identified below, your Benefits will be</p>	<p>[Designated Network]</p> <p>[[50 - 100]%</p> <p>Network</p> <p>[50 - 100]%</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[50 - 250] per service is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>enhanced as described:]</p> <p>[Specialties:]</p> <ul style="list-style-type: none"> • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] <p>[Enhanced Benefits:]</p> <ul style="list-style-type: none"> • [The Coinsurance you pay for Physician's Fees from a Designated Network Physician will be reduced to [0 - 50]% or \$[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of \$[10 - 1,000].] <p>[You can determine the specific services for which enhanced Benefits are available by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone</p>			<p>Occurrence Deductible of \$[50 - 250] per service is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>number on your ID card.]</p> <p>[Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Non-Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.]</p> <p>[Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.]</p>	<p>Non-Network</p> <p>[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[50 - 250] per service is satisfied]</p>
<p>[22.] Physician's Office Services - Sickness and Injury</p>			
<p align="center">[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits you must obtain prior authorization as soon as is reasonably possible before [Genetic Testing - BRCA] [Genetic Testing, including BRCA Genetic Testing] is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
	<p>[Designated Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[When you choose to seek care [as a result of certain diagnoses or] from Designated Network Physicians as identified below, your Benefits will be</p>	<p>per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for allergy injections when no other service is provided during the office visit]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p> <p>[Yes, when</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>enhanced as described:]</p> <p>[Specialties:]</p> <ul style="list-style-type: none"> • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] <p>[Enhanced Benefits:]</p> <ul style="list-style-type: none"> • [The Copayment you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to \$[0 - 1,000]. [The maximum reduction in Copayments is \$[10 - 1,000].]] • [The Coinsurance you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to [0 - 	<p>Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in</p>	<p>Benefits are subject to Coinsurance]</p>	<p>Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>50]% or \$[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of \$[10 - 1,000].]</p> <p>[You can determine the specific specialties for which enhanced Benefits are available by going to [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.]</p> <p>[In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office:</p> <ul style="list-style-type: none"> • [Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient.</i>] • [Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.</i>] • [Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient.</i>] • [Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>] • [Outpatient surgery procedures described under <i>Surgery - Outpatient.</i>] • [Outpatient therapeutic procedures described under 	<p>that year]</p> <p>[100% for allergy injections when no other service is provided during the office visit]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<ul style="list-style-type: none"> Therapeutic Treatments - Outpatient.] [Rehabilitation therapy procedures described under Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment].]] 	<p>Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for allergy injections when no other service is provided during the office visit]</p>		
<p>¹Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude. ²If Maternity Services are excluded, Complications of Pregnancy must always be included.]</p> <p>[23.] Pregnancy - [1]Maternity Services] [2]Complications of Pregnancy only]</p>			
<p><i>[Include when benefits are provided for maternity services.]</i></p> <p align="center">[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p> <p><i>[Include when benefits are provided for complications of pregnancy only.]</i></p> <p align="center">[Prior Authorization Requirement]</p>			

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[For Non-Network Benefits you must obtain prior authorization five business days before admission for scheduled admissions or within one business day or the same day, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p> <p>It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.</p>			
<p><i>[Include when benefits are provided for maternity services. Bracketed text within is plan design variable.]</i></p> <p>[Network]</p> <p>[Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> [except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]]</p> <p>[Non-Network]</p> <p>[Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> [except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]]</p> <p><i>[Include when benefits are provided for complications of pregnancy only.]</i></p> <p>[Network]</p> <p>[Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p> <p>[Non-Network]</p> <p>[Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>			
<p>[24.] Preventive Care Services</p>			
<p>Physician office services</p> <ul style="list-style-type: none"> Well baby and well child care includes, but is limited to, 20 	<p>Network</p> <p>100%</p>	<p>No</p>	<p>No</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>visits at approximately the following age intervals: birth, two weeks, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, three years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years.</p> <p>No Copayment, Coinsurance or deductible will be applicable to Network or non-Network children's immunizations.</p>	<p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not available except for children under the age of 19.]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not available except for children under the age of 19.]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Lab, X-ray or other preventive tests</p>	<p>first [#] visits in a year; [50 - 90]% for any subsequent visits in that year</p> <p>[100% for immunizations when no other service is provided during the office visit.]</p> <p>[Non-Network Benefits are not available.]</p> <p>Network</p> <p>100%</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[Non-Network Benefits are not available.]</p>	<p>No</p> <p>[Yes] [No]</p> <p>[Non-Network Benefits are not available.]</p>	<p>No</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Non-Network Benefits are not available.]</p>
<p><i>Prosthetics are a mandated benefit in Arkansas.</i></p> <p>[25.] Prosthetic Devices and Services</p>	<p>[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits you must obtain prior authorization before obtaining prosthetic devices [that exceed \$[1,000 - 5,000] in cost per device]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>		
<p>Benefits for replacement are limited to a single purchase of each type of prosthetic device every three years</p>	<p>[Network]</p> <p>[[50 - 100]%]</p> <p>[Non-Network]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[[50 - 100]%] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]
[26.] Reconstructive Procedures			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]</p>			
	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]</i></p> <p>[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]</i></p> <p>[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p>		
[27.] [Rehabilitation Services -			

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Outpatient Therapy [and Manipulative Treatment]			
<p>[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits you must obtain prior authorization five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy] or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
<p>[Limited per year as follows:</p> <ul style="list-style-type: none"> • [[10 -100] visits of physical therapy.] • [[10 -100] visits of occupational therapy.] • [[10 -100] Manipulative Treatments.] • [[10 -100] visits of speech therapy.] • [[10 -100] visits of pulmonary rehabilitation therapy.] • [[10 -100] visits of cardiac rehabilitation therapy.] • [[10 -100] visits of post-cochlear implant aural therapy.] • [[10 - 100] visits of cognitive rehabilitation therapy.] • [[10 -100] visits of vision therapy.]] <p>[Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,], [and] cognitive rehabilitation therapy [and vision therapy] is limited to [10 - 160] visits per year.]</p>	<p>[Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[Non-Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>1,000] per day]</p> <p>[100% after you pay a Copayment of \$[50 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[50 - 1,000] per day to a maximum Copayment of \$[50 - 10,000] per Inpatient Stay]</p>		<p>- 2,000] per [day] [Inpatient Stay] is satisfied]</p>
<p><i>[Include as standard for groups of 2 to 15]</i></p> <p>[30.] Substance Use Disorder Services</p>	<p align="center">[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits for a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>		
<p><i>[Limits will not apply to groups of 51+.]</i></p> <p>[Inpatient Substance Use Disorder Services are limited to [10 - 100] days per year.]</p> <p>[Outpatient Substance Use Disorder Services are limited to [10 - 100] visits per year.]</p> <p>[Non-Network Benefits for inpatient Substance Use Disorder Services are limited to [10 - 100] days per year.]</p> <p>[Non-Network Benefits for outpatient Substance Use Disorder Services are</p>	<p>[Network]</p> <p><i>[Inpatient]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 -</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>limited to [10 - 100] visits per year.]</p> <p>[Benefits for any combination of <i>Substance Use Disorder Services</i> described in this section and <i>Mental Health Services</i> described above are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] <p>[Benefits for any combination of <i>Substance Use Disorder Services</i> described in this section and <i>Mental Health Services</i> and <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i> described above are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] 	<p>1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p><i>[Outpatient]</i></p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p> <p><i>[Non-Network]</i></p> <p><i>[Inpatient]</i></p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Copayment of \$[100 - 2,000] per Inpatient Stay</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay</p> <p><i>[Outpatient]</i></p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>
<p>[31.] Surgery - Outpatient</p>			
<p><i>[¹Does not apply if prior authorization is required for all pain management.]</i></p>			
<p align="center">[Prior Authorization Requirement]</p> <p>[For Non-Network Benefits [for all outpatient surgeries] [for [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [¹pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgery]] you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
	<p><i>[Designated Network]</i></p> <p>[[50 - 100]%</p> <p>[[50 - 100]% at an ambulatory surgical center]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[10 - 1,000] per date</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>[[50 - 100]% at an outpatient Hospital-based surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service at an ambulatory surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service at an outpatient Hospital-based surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year at an ambulatory surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year at an outpatient Hospital-based surgical center]</p>		<p>of service is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as follows:]</p> <ul style="list-style-type: none"> [The Copayment you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [\$0 - 1,000]. [The maximum reduction in Copayments is \$[10 - 1,000].]] [The Coinsurance you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [0 - 50]% or \$[10 - 1,000] will be applied toward any applicable deductible if not already met, to a maximum of \$[10 - 1,000].] <p>[You can determine the specific surgical procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>	<p>Network</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at an ambulatory surgical center]</p> <p>[[50 - 100]% at an outpatient Hospital-based surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service at an ambulatory surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service at an outpatient Hospital-based surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year at an ambulatory surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[10 - 1,000] per date of service is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>service, to a maximum Copayment of \$[10 - 5,000] per year at an outpatient Hospital-based surgical center]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[10 - 1,000] per date of service is satisfied]</p>
<p>[32.] Temporomandibular Joint Services</p>			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[For Non-Network Benefits you must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p align="center">[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions.]</p>			
<p>[Limited to \$[1,000 - 20,000] per year.]</p>	<p>[Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p> <p>[Non-Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p> <p>[Non-Network Benefits are not available.]</p>		
<p>[33.] Therapeutic Treatments - Outpatient</p>			

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>[100% after you pay a Copayment of \$[25 - 100] per treatment at a free-standing center]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment at an outpatient Hospital-based center]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 100] per treatment is satisfied]</p>
<p>[34.] Transplantation Services</p>			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid. [Non-Network Benefits will apply.]</p> <p>[For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p> <p>[In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>			
<p>For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.</p> <p>[Non-Network Benefits are limited to \$[30,000 - 250,000] per transplant.]</p>	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p>		

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p> <p>[Non-Network Benefits are not available.]</p>		
[35.] Urgent Care Center Services			
<p>[Limited to [2 - 10] visits per year.]</p> <p>[In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center:</p> <ul style="list-style-type: none"> • [Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient.</i>] • [Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.</i>] • [Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient.</i>] • [Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>] • [Outpatient surgery procedures described under <i>Surgery - Outpatient.</i>] • [Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i>] • [Rehabilitation therapy 	<p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit to a maximum Copayment of \$[5 - 5,000] per year]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 150] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>procedures described under <i>Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment].</i>]</p>	<p>Non-Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit to a maximum Copayment of \$[5 - 5,000] per year]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 150] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>
<p>[36.] [Vision Examinations]</p>			
<p>[Limited to [1 exam] [[2-3] exams] per year.]</p> <p>[Limited to [1 exam] [[2-3] exams] every [2 - 3] years.]</p>	<p>[Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[Non-Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not available.]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Non-Network Benefits are not available.]</p>
[37.] [Wigs]			

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[Limited to \$[100 - 1,000] per year.]	[Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[Limited to \$[100 - 5,000] every [24 - 36] months.]	[Non-Network] [[50 - 100]%] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]	[Yes] [No] [Non-Network Benefits are not available.]

Additional Benefits Required By Arkansas Law

[38.] Dental Services - Anesthesia and Hospitalization

Pre-service Notification Requirement

Any applicable notification requirements will be the same as those stated under each Covered Health Service Category in this *Schedule of Benefits*.

Network

[Benefits will be the same as those stated under each Covered Health Service Category in this *Schedule of Benefits*.]

Non-Network

[Benefits will be the same as those stated under each Covered Health Service Category in this *Schedule of Benefits*.]

[39.] In Vitro Fertilization Services

¹*Include applicable reduction in Benefits or no Benefits.*

Pre-service Notification Requirement

You must notify us as soon as the possibility of the need for in vitro fertilization arises. If you fail to notify us as required, [¹Benefits will be reduced to [50 - 95]% of Eligible Expenses] [¹you will be responsible for paying all charges and no Benefits will be paid].

Network

[Benefits will be the same as those stated under each Covered Health Service Category in this *Schedule of Benefits*.]

Non-Network

[Benefits will be the same as those stated under each Covered

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Health Service Category in this <i>Schedule of Benefits.</i>			
[40.] Medical Foods			
¹ Include applicable reduction in Benefits or no Benefits.			
Pre-service Notification Requirement			
You must notify us as soon as the possibility of the need for in vitro fertilization arises. If you fail to notify us as required, [¹ Benefits will be reduced to [50 - 95]% of Eligible Expenses] [¹ you will be responsible for paying all charges and no Benefits will be paid].			
	Network [50 - 100]% Non-Network Same as Network	[Yes] [No] Same as Network	[Yes] [No] Same as Network
<i>Mandated offer in Arkansas.</i>			
[[41.] Musculoskeletal Disorders of the Face, Neck or Head]			
[Pre-service Notification Requirement]			
[Depending upon where the Covered Health Service is provided, any applicable notification or authorization requirements will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]			
	[¹ Designated Network] [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>] [Network] [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>] [Non-Network] [Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each		

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<i>Covered Health Service category in this Schedule of Benefits.]</i>			
[[42.] Orthotic Devices and Services			
<p><i>Include if notification is required.</i></p> <p><i>¹Include when notification applies only to orthotics that exceed a minimum dollar amount and insert applicable dollar amount.</i></p> <p><i>²Include applicable reduction in Benefits or no Benefits.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[For Non-Network Benefits you must notify us before obtaining orthotic devices [¹that exceed \$[1,000 - 5,000] in cost per device]. If you fail to notify us as required, [²Benefits will be reduced to [50 - 95]% of Eligible Expenses] [²you will be responsible for paying all charges and no Benefits will be paid].]</p>			
Benefits for replacements are limited to a single purchase of each type of orthotic device every three years.	<p>Network [50 - 100%]</p> <p>Non-Network [50 - 100%]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>

Eligible Expenses

¹Include if non-network RAPLs and consultants at a network facility are paid as network benefits at less than billed charges.]

Eligible Expenses are the amount we determine that we will pay for Benefits. For [Designated Network Benefits and] Network Benefits [¹for Covered Health Services provided by a Network provider], you are not responsible for any difference between Eligible Expenses and the amount the provider bills. [¹For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by us), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below.] For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

[Include if plan includes ability to determine alternate levels of benefits.]

[If one or more alternative health services that meets the definition of a Covered Health Service in the *Certificate* under *Section 9: Defined Terms* are clinically appropriate and not more costly than an alternative health service that is at least as likely to produce equivalent therapeutic or diagnostic results as to their prevention, diagnosis or treatment of a Sickness, Injury, [Mental Illness,] [mental illness,]

substance use disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on *Generally Accepted Standards of Medical Practice*, which for some Covered Health Services may be addressed in our clinical policies.]

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

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

[Include if RAPLs and consultants are paid as network benefits at less than billed charges.]

- [For Covered Health Services received at a Network facility on a non-Emergency basis from a [radiologist] [,] [and] [anesthesiologist] [,] [and] [pathologist] [,] [and] [consulting Physician] [,] [and] [neonatologist] [,] [and] [intensivist] [,] [and] [assistant surgeon] [and] [surgical assistant], the Eligible Expense is based on [[110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market] [50 - 100]% of the provider's billed charge].

When a rate is not published by *CMS* for the service, we use 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, Inc.* If the *Ingenix, Inc.* relative value scale becomes no longer available, a comparable scale will be used. We and *Ingenix, Inc.* are related companies through common ownership by *UnitedHealth Group*.

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 Eligible Expense is based on 50% of the provider's billed charge.]

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

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:

[PHCS payment option.]

[¹Include if RAPLs and consultants are paid as non-network benefits.]

- [Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.
- If rates have not been negotiated, then one of the following amounts:
 - ◆ For Covered Health Services other than Pharmaceutical Products [¹and services from the specific providers identified below], Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.

[²Include when benefits are provided for either Mental Health Services or Substance Use Disorder Services.]

If no fee information is available for a Covered Health Service, the Eligible Expense is based on [50 - 100]% of the provider's billed charge², except that certain Eligible Expenses for [Mental Health Services] [and] [Substance Use Disorder Services] are based on 80% of the billed charge].

- ◆ [²For [Mental Health Services] [and] [Substance Use Disorder Services] the Eligible Expense will be reduced by [5 - 30]% for Covered Health Services provided by a psychologist and by [5 - 40]% for Covered Health Services provided by a masters level counselor.]

- ◆ When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [110 - 200]% 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.

When a rate is not published by *CMS* for the service we use 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.

- ◆ [¹For Covered Health Services received on a non-Emergency basis from a [radiologist] [,] [and] [anesthesiologist] [,] [and] [pathologist] [,] [and] [consulting Physician] [,] [and] [neonatologist] [,] [and] [intensivist] [,] [and] [assistant surgeon] [and] [surgical assistant], the Eligible Expense is based on [[110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market] [50 - 100]% of the provider's billed charge].

When a rate is not published by *CMS* for the service, we use 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, Inc.* If the *Ingenix, Inc.* relative value scale becomes no longer available, a comparable scale will be used. We and *Ingenix, Inc.* are related companies through common ownership by *UnitedHealth Group.*]]

[MNRP payment option.]

- [Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.
- If rates have not been negotiated, then one of the following amounts:

[¹Include if RAPLs and consultants are paid as non-network benefits.]

- ◆ [¹Except for services from the specific providers identified below,] Eligible Expenses are determined based on [110 - 200]% 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.
- ◆ [¹For Covered Health Services received on a non-Emergency basis from a [radiologist] [,] [and] [anesthesiologist] [,] [and] [pathologist] [,] [and] [consulting Physician] [,] [and] [neonatologist] [,] [and] [intensivist] [,] [and] [assistant surgeon] [and] [surgical assistant], the Eligible Expense is based on [[110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market] [50 - 100]% of the provider's billed charge].]
- ◆ When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
 - For services other than Pharmaceutical Products, we use 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, Inc.* If the *Ingenix, Inc.* relative value scale becomes no longer available, a comparable scale will be used. We and *Ingenix, Inc.* are related companies through common ownership by *UnitedHealth Group.*

- ▶ For Pharmaceutical Products, we use 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.

[²Include when benefits are provided for either Mental Health Services or Substance Use Disorder Services.]

- ◆ 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 Eligible Expense is based on 50% of the provider's billed charge², except that certain Eligible Expenses for [Mental Health Services] [and] [Substance Use Disorder Services] are based on 80% of the billed charge.
- ◆ ²For [Mental Health Services] [and] [Substance Use Disorder Services] the Eligible Expense will be reduced by [5 - 30]% for Covered Health Services provided by a psychologist and by [5 - 40]% for Covered Health Services provided by a masters level counselor.]

We update the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.]

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

Provider Network

[Include when Core product is supported.]

We arrange for health care providers to participate in a Network. [The UnitedHealthcare Core product has a limited Network of providers.] Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider [to be certain that the provider is a UnitedHealthcare Core Network provider]. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Continuity of Care

Continuity of care is provided under the Policy. In order for health services to be covered as Network Benefits, you must notify the company immediately if either of the following situations applies to you:

- Newly Eligible Persons who are being treated by a Non-Network provider for a current episode of an acute condition may continue to receive treatment from the Non-Network provider until the earlier of (1) the end of the current episode of treatment or (2) 90 days.
- Covered Persons who are being treated for a current episode of an acute condition by a Network provider when the provider's contract terminates may continue to receive treatment from that provider until the earlier of (1) the end of the current episode of treatment or (2) 90 days.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses at our discretion.

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

You or your Network Physician must notify us of special service needs (such as transplants, [ventricular assist device implantation](#)) or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

UnitedHealthcare [Options PPO]

[UnitedHealthcare Insurance Company]

Schedule of Benefits

Accessing Benefits

[Designated network benefits are variable for several benefit categories. Include references throughout the schedule as needed when designated network benefits are available for any category.]

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

[Designated Network Benefits] apply to Covered Health Services that are provided by a Network Physician or other provider that we have identified as a Designated Facility or Physician. Designated Network Benefits are available only for specific Covered Health Services as identified in the *Schedule of Benefits* table below.]

[Include if non-network RAPLs at a network facility are paid as network benefits.]

[Network Benefits] apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.]

[Include when non-network RAPLs and consultants at a network facility are paid as network benefits and when non-emergent network benefits for these services provided by non-network providers will not be paid at billed charges.]

[Network Benefits] apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. Network Benefits also apply to Covered Health Services that are provided at a Network facility by a non-Network [radiologist] [,] [or] [anesthesiologist] [,] [or] [pathologist] [,] [or] [consulting Physician] [,] [or] [neonatologist] [,] [or] [intensivist] [,] [or] [assistant surgeon] [or] [surgical assistant], however such Covered Health Services, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. As a result you will be responsible for the difference between the amount billed by the provider and the amount we determine to be an Eligible Expense for reimbursement.]

[Include when non-network RAPLs and consultants at a network facility are paid as non-network benefits.]

[Network Benefits] apply to Covered Health Services that are provided by a Network Physician or other Network provider. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility. Emergency Health Services are always paid as Network Benefits.]

[Include when non-network RAPLs and consultants at either a network or non-network facility are paid as non-network benefits.]

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. [Covered Health Services, when not Emergency Health Services, provided in a Network facility by a non-Network [radiologist] [,] [or] [anesthesiologist] [,] [or] [pathologist] [,] [or] [consulting Physician] [,] [or] [neonatologist] [,] [or] [intensivist] [,] [or] [assistant surgeon] [or] [surgical assistant] will be paid as Non-Network Benefits.]

[Include when the enhanced benefits program is sold.]

[You may have an opportunity to elect to receive Covered Health Services from certain Network providers that we've identified as Designated Physicians or Designated Facilities. When you choose to seek care from certain Designated providers, the level of Benefits available to you is enhanced. You can determine the specific situations for which enhanced Benefits are available by going to [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[¹Include when shared savings program applies.]

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

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a [\[UnitedHealthcare\]](#) Policy. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

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

Prior Authorization

[¹Include when network providers are responsible for prior authorization for network benefits.]

We require prior authorization for certain Covered Health Services. [In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization.] Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

[¹We recommend that you confirm with us [that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.]

When you choose to receive certain Covered Health Services [¹from non-Network providers], you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

To obtain prior authorization, call the telephone number for *Customer Care* on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to determine how far in advance you must obtain prior authorization.

[Include bracketed variable benefit category listed below if: a) the benefit is included in the plan design and b) prior authorization is required. Include dollar amounts as applicable.]

- [_____]
- Ambulance - non-emergent air and ground.
- Clinical trials.
- [Congenital heart disease surgery.]
- [Dental services - accidental.]
- Dental services - anesthesia and hospitalization and ambulatory surgery.
- [Diabetes equipment - insulin pumps [over \$[1,000 - 5,000]].]
- [Durable Medical Equipment [over \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)].]
- [Medical Foods.]

[Include when prior authorization is required for only BRCA genetic testing.]

- [Genetic Testing - BRCA.]

[Include when prior authorization is required for all genetic testing.]

- [Genetic Testing, including BRCA Genetic Testing.]
- [Hearing aids [that exceed \$[1,000 - 5,000] in retail purchase cost].]
- [Home health care.]
- [Hospice care - inpatient.]
- Hospital inpatient care - all scheduled admissions [and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery].
- [Infertility services.]
- In vitro fertilization services.
- [Lab, X-ray and diagnostics - sleep studies.]
- [Lab, X-ray and major diagnostics - CT, PET Scans, MRI, MRA, Nuclear Medicine and Capsule Endoscopy.]

Include when group purchases benefits for musculoskeletal disorders.

- [Musculoskeletal disorders of the face neck or head.]
-
- [Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.]
- [Neurobiological disorders - Autism Spectrum Disorder services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), Intensive

Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Applied Behavioral Analysis (ABA).]

- [Obesity surgery.]

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

- Orthotics devices [¹over\$[1,000-5,000]].
- [Pain management.]
- [Pharmaceutical Products - IV infusions only.]
- [Certain Pharmaceutical Products. You may determine whether a particular Pharmaceutical Product requires authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

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

- Prosthetic devices [¹over \$[1,000 - 5,000]].]
- Reconstructive procedures, including breast reconstruction surgery following mastectomy [and breast reduction surgery].
- [Rehabilitation services [and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy].]
- [Scopic procedures - outpatient diagnostic and therapeutic.]
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- [Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.]

[¹ Do not include pain management procedures if prior authorization is required for all pain management services above.]

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [¹pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgeries]].]
- [Temporomandibular joint services.]
- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound]].]
- Transplants.
- [Ventricular assist device implantation. You must obtain prior authorization as soon as the possibility of implantation arises except in cases of Emergency implantations of partial assist devices.]

[Include paragraph below if plan includes ability to determine alternate levels of benefits.]

[Here and throughout the document, include defined capitalized term if Mental Health Benefits are sold; include lower case reference if Mental Health Benefits are not sold.]

[As we determine, if one or more alternative health services that meets the definition of a Covered Health Service in the *Certificate* under *Section 9: Defined Terms* are clinically appropriate and not more costly than an alternative health service that is at least as likely to produce equivalent therapeutic or diagnostic results as to their prevention, diagnosis or treatment of a Sickness, Injury, [Mental Illness,] [mental illness,] substance use disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on *Generally Accepted Standards of Medical Practice*, which for some Covered Health Services may be addressed in our clinical policies. After you contact us for prior authorization, we will identify the Benefit level available to you.

These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.]

[¹Include when network providers are responsible for prior authorization for network benefits.]

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

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.

[The Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

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

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

Payment Term And Description	Amounts
Annual Deductible	
<p><i>[Annual deductible is plan design variable. Include applicable provisions to support the following:</i></p> <p>¹Annual deductible applies only to non-network benefits.</p> <p>²Outpatient Prescription Drug Rider is sold and the annual deductible applies to any combination of medical and RX benefits.</p> <p>³Outpatient Prescription Drug Rider with separate copayments for preventive medications is sold and the annual deductible does not apply to preventive medications.</p> <p>⁴Outpatient Prescription Drug Rider is sold and when the annual deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the annual deductible.</p> <p>⁵There is a deductible for designated and network benefits and the network and non-network amounts apply to the designated network and network annual deductible.</p> <p>⁶Designated network benefits apply to any category.]</p> <p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive [¹Non-Network] Benefits. [²The Annual Deductible applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>. [³Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [⁴Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the <i>Outpatient Prescription Drug Rider</i> are not subject to payment of the Annual Deductible.] [⁵The Annual Deductible for [⁶Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drugs provided under the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include applicable provisions to support the following:</i></p> <p>¹Day/visit limits are reduced by the number of days/visit used toward meeting the deductible.</p> <p>²Carry-over provision applies.</p> <p>³Roll-over provision applies in any circumstance.</p> <p>⁴Roll-over provision applies only to groups changing from calendar to policy year. ⁵Include when roll-over applies only to the individual deductible.</p> <p>⁶Include only when a per occurrence deductible applies.]</p> <p>[¹Amounts paid toward the Annual Deductible for Covered</p>	<p>¹Include separate network and non-network headings and statements when annual deductible provision applies separately.]</p> <p>²Include when designated network benefits apply to any category and when the designated network and network deductible is combined.]</p> <p>³Include when designated network and network are separate.]</p> <p>[¹ [² Designated Network and] Network] [³ Designated Network]</p> <p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</p> <p>[No Annual Deductible.]</p> <p>[³ Network]</p> <p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered</p>

Payment Term And Description	Amounts
<p>Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.]</p> <p>[²Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.]</p> <p>[³When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.]</p> <p>[⁴When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [⁵This roll-over feature applies only to the individual Annual Deductible.]]</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>[⁶The Annual Deductible does not include any applicable Per Occurrence Deductible.]</p>	<p>Persons in a family.]</p> <p>[No Annual Deductible.]</p> <p>[¹ Non-Network]</p> <p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</p> <p>[No Annual Deductible.]</p> <p><i>⁴Include the combined network and non-network heading and statements when annual deductible provision applies separately to combined network and non-network benefits.</i></p> <p><i>⁵Include when designated network benefits apply to any category.]</i></p> <p>[⁴ ⁵ Designated Network,] Network and Non-Network]</p> <p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</p>
<p><i>[Per occurrence deductible is plan design variable.]</i></p>	

Payment Term And Description	Amounts
<p>[Per Occurrence Deductible]</p>	
<p>[The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services.</p> <p>You are responsible for paying the lesser of the following:</p> <ul style="list-style-type: none"> • The applicable Per Occurrence Deductible. • The Eligible Expense.] 	<p>[When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.]</p>
<p>Out-of-Pocket Maximum</p>	
<p><i>[Out-of-pocket maximum is plan design variable. Include applicable provisions to support the following:</i></p> <p>¹<i>Includes the annual deductible.</i></p> <p>²<i>Includes the per occurrence deductible.</i></p> <p>³<i>Includes copayments.</i></p> <p>⁴<i>Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.</i></p> <p>⁵<i>OOPM applies to designated and network benefits and the network and non-network amounts paid under the RX rider apply to the designated network and the network OOPM.</i></p> <p>⁶<i>Include bracketed designated network reference when designated network benefits apply to any category.]</i></p> <p>The maximum you pay per year for [¹the Annual Deductible,] [²the Per Occurrence Deductible,] [³Copayments] [¹⁻²⁻³or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [⁴The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.] [⁵The Out-of-Pocket Maximum for [⁶Designated Network and] Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when plan design does not apply all copayments/coinsurance to the OOPM.]</i></p> <p>[[Copayments] [and] [Coinsurance] for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Maximum does not include any of the</p>	<p>¹<i>Include separate network and non-network headings and statements when OOPM provision applies separately.]</i></p> <p>²<i>Include when designated network benefits apply to any category and when the designated network and network OOPM is combined.]</i></p> <p>³<i>Include when designated network and network are separate.]</i></p> <p>[¹ [² Designated Network and] Network] [³ Designated Network]</p> <p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p>

Payment Term And Description	Amounts
<p>following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> Any charges for non-Covered Health Services. <p><i>[Include bullet if prior authorization requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.]</i></p> <ul style="list-style-type: none"> [The amount Benefits are reduced if you do not obtain prior authorization as required.] Charges that exceed Eligible Expenses. Copayments or Coinsurance for any Covered Health Service identified in the <i>Schedule of Benefits</i> table that does not apply to the Out-of-Pocket Maximum. <p><i>[Include when an Outpatient Prescription Drug Rider is sold and copayments/coinsurance do not apply to the overall OOPM.]</i></p> <ul style="list-style-type: none"> [Copayments or Coinsurance for Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.] 	<p>[No Out-of-Pocket Maximum.]</p> <p>⁸ Network</p> <p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p> <p>[No Out-of-Pocket Maximum.]</p> <p>¹ Non-Network</p> <p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum includes</p>

Payment Term And Description	Amounts
	<p>the Per Occurrence Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p> <p>[No Out-of-Pocket Maximum.]</p> <p>⁴Include combined network and non-network heading and statements below when OOPM provision applies to combined network and non-network benefits and delete the separate "Network" and "Non-Network" provisions above.]</p> <p>⁵Include when designated network benefits apply to any category.]</p> <p>[⁴ ⁵ Designated Network,] Network and Non-Network]</p> <p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p> <p>[No Out-of-Pocket Maximum.]</p>
<p>[Annual maximum benefit is plan design variable. Include applicable provisions to support the following:</p> <p>¹Outpatient Prescription Drug Rider is sold.]</p> <p>[Annual Maximum Benefit]</p>	

Payment Term And Description	Amounts
<p>[The maximum amount we will pay for Benefits during the year.] [¹The Annual Maximum Benefit applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.]</p>	<p>¹ <i>Include separate network and non-network headings and statements when the annual maximum benefit applies separately.</i></p> <p>² <i>Include when designated network benefits apply to any category and when the designated network and network maximum is combined.</i></p> <p>³ <i>Include when designated network and network are separate.</i></p> <p>⁴ <i>Include when combined network and non-network maximums apply.</i></p> <p>[¹ ² Designated Network and] Network] [³ Designated Network]</p> <p>[\$[2,000 - 2,500,000] per Covered Person.]</p> <p>[No Annual Maximum Benefit.]</p> <p>[³ Network]</p> <p>[\$[2,000 - 2,500,000] per Covered Person.]</p> <p>[No Annual Maximum Benefit.]</p> <p>[¹ Non-Network]</p> <p>[\$[2,000 - 2,500,000] per Covered Person.]</p> <p>[No Annual Maximum Benefit.]</p> <p>[⁴ ² Designated Network,] Network and Non-Network]</p> <p>[\$[2,000 - 2,500,000] per Covered Person.]</p>
<p>Copayment</p>	
<p>Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.</p> <p>[For Pharmaceutical Products, your Copayments are determined by the tier to which the Pharmaceutical Product List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]</p> <p>Please note that for Covered Health Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> • The applicable Copayment. • The Eligible Expense. <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	

Payment Term And Description	Amounts
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.	
[For Pharmaceutical Products, your Coinsurance is determined by the tier to which the Pharmaceutical Product List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]	
Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.	

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design.]

[Include the following variables according to plan design:

- Benefit limits and levels.*
- Prior authorization requirements and any penalty for failure to prior authorize*
- Designated network benefit levels as applicable.*
- Any other specific conditions for coverage described within the category.]*

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
1. [Acupuncture Services]			
[Limited to [10 - 100] treatments per year.]	[Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[Limited to [10 - 100] treatments per year, not to exceed \$[100 - 5,000] in Eligible Expenses per year.]	[100% after you pay a Copayment of \$[5 - 75] per visit]	[Yes, when Benefits are subject to Coinsurance]	[Yes, when Benefits are subject to Coinsurance]
[Limited to \$[100 - 5,000] in Eligible Expenses per year.]	[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]		[Yes, after the Per Occurrence Deductible of \$[5 - 75] per visit is satisfied]
	[Non-Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[100% after you pay a Copayment of \$[5 - 75] per visit]	[Yes, when Benefits are subject to	[Yes, when Benefits are subject to

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.</p>	<p>to a per day maximum of \$[2,500 - 10,000]</p> <p>Non-Network Same as Network</p> <p>Network <i>Ground Ambulance:</i> [50 - 100%] [100% after you pay a Copayment of \$[25 - 300] per transport] [100% after you pay a Copayment of \$[300 - 1,000] per day] [100% after you pay a Copayment of \$[300 - 1,000] per day, up to a per day maximum of \$[300 - 1,000]]</p> <p><i>Air Ambulance:</i> [50 - 100%] [100% after you pay a Copayment of \$[25 - 2,500] per transport] [100% after you pay a Copayment of \$[2,500 - 10,000] per day] [100% after you pay a Copayment of \$[2,500 - 10,000] per day, up to a per day maximum of \$[2,500 - 10,000]]</p> <p>Non-Network Same as Network</p>	<p>Same as Network</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>Same as Network</p>	<p>Same as Network</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 1,000] per [transport] [day] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 10,000] per [transport] [day] is satisfied]</p> <p>Same as Network</p>
<p>[3.] Clinical Trials</p>			

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Prior Authorization Requirement</p> <p>You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
<p>Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i>.</p> <p>Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)</p>	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
<p>[4.] [Congenital Heart Disease Surgeries]</p>			
<p>[Prior Authorization Requirement]</p> <p>[For Designated Network Benefits you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you do not obtain prior authorization and if, as a result, the CHD services are not performed at a Designated Facility, Designated Network Benefits will not be paid.] [Non-Network Benefits will apply.]</p> <p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
<p>[Designated Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac</p>	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i></p> <p>[Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i></p> <p>[For Network Benefits, CHD surgeries must be received at a Designated Facility.</p> <p>Non-Network Benefits include services provided at a Network facility that is not a Designated Facility and services provided at a non-Network facility.</p> <p>Non-Network Benefits under this section include only the CHD surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i></p>	<p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p>[Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p>[Non-Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 -</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	2,000] per Inpatient Stay] [100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]		Stay] is satisfied]
[5.] [Dental Services - Accident Only]			
[Prior Authorization Requirement]			
[For Network and Non-Network Benefits you must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Limited to \$[2,000 - 5,000] per year. Benefits are further limited to a maximum of \$[500 - 1,500] per tooth.]	[Network] [[50 - 100]%] [100% after you pay a Copayment of \$[5 - 75] per visit] [Non-Network] [Same as Network]	[Yes] [No] [Same as Network]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 75] per visit is satisfied] [Same as Network]
[6.] Diabetes Services			

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
five] years].]	<p>the Out-of-Pocket Maximum.]]</p> <p><i>[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]</p> <p>Benefits for diabetes supplies will be the same as those stated in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p>Non-Network</p> <p><i>[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]</i></p> <p>[Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]</i></p> <p>[For diabetes equipment, Benefits will be the same as those stated under <i>Durable Medical Equipment</i>.</p> <p>For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p><i>[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to</p>		

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>the Out-of-Pocket Maximum.]</p> <p>Benefits for diabetes supplies will be the same as those stated in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p>		
[7.] [Durable Medical Equipment]			
[Prior Authorization Requirement]			
<p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p>			
<p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization before obtaining any Durable Medical Equipment [that exceeds \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>[Limited to \$[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two - five] years]. [This limit does not apply to wound vacuums[, which are subject to a separate limit of \$[4,500 - 13,500] per year and limited to a single purchase (including repair/replacement) every [year] [[two - five] years]].]</p> <p>[Limited per year as follows:</p> <ul style="list-style-type: none"> • [\$[500 - 10,000] in Eligible Expenses for Tier 1. Tier 1 includes disposable supplies necessary for the effective use of covered Durable Medical Equipment.] • [\$[10,001 - 25,000] in Eligible Expenses for Tier 2.] 	<p>[Network]</p> <p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 500] per purchase is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<ul style="list-style-type: none"> • [[\$25,001 - 100,000] in Eligible Expenses for Tier 3.] <p>These Tier limits include repair. Benefits for replacement are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].</p> <p>[Benefits are [further] limited to a single Mobility Device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair of the Mobility Device are limited to once every three years. We may, upon review, replace a defective Mobility Device rather than repair it. Benefits are not available for repair or replacement of a Mobility Device resulting from abuse, neglect or normal wear.]</p> <p>[Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every three years. Speech aid and tracheo-esophageal voice devices are [not] included in the annual limits stated above.]</p>	<p>[Non-Network]</p> <p>[[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 500] per purchase is satisfied]</p>
<p>[8.] Emergency Health Services - Outpatient</p>			
<p>Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health</p>	<p>Network</p> <p>[[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.</p> <p>[In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed as an Emergency Health Service:</p> <ul style="list-style-type: none"> • [Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient.</i>] • [Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.</i>] • [Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient.</i>] • [Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>] • [Outpatient surgery procedures described under <i>Surgery - Outpatient.</i>] • [Outpatient therapeutic 	<p>[100% after you pay a Copayment of \$[5 - 500] per visit. [If you are admitted as an inpatient to a Network Hospital [directly from the Emergency room] [within 24 hours of receiving outpatient Emergency treatment for the same condition], you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.]]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; 100% after you pay a Copayment of \$[50 - 650] for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; 100% after you pay a</p>	<p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 700] per visit is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<ul style="list-style-type: none"> procedures described under <i>Therapeutic Treatments - Outpatient.</i> [Rehabilitation therapy procedures described under <i>Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment].</i>] 	<p>Copayment of \$[50 - 650] per visit for the next [#] visits in a year; 100% after you pay a Copayment of \$[100 - 700] for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for the first [#] visits in a year; 100% after you pay a Copayment of \$[50 - 650] per visit for the next [#] visits in a year; 100% after you pay a Copayment of \$[100 - 500] for the next [#] visits in a year; 100% after you pay a Copayment of \$[150 - 700] for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 500] per visit for a condition defined as an Emergency; 100% after you pay a Copayment of \$[50 - 650] per visit for a condition that does not meet the definition of an Emergency]</p> <p>Non-Network Same as Network</p>	<p>Same as Network</p>	<p>Same as Network</p>
<p><i>Include as standard for groups of 2 to 15 and 15+.</i></p> <p>[9.] Hearing Aids</p>			

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[Network Benefits are limited to [40 - 200] visits per year and Non-Network Benefits are limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.]</p> <p>[This visit limit does not include any service which is billed only for the administration of intravenous infusion.]</p>	<p>Non-Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 50] per visit]</p>	<p>[Yes] [No]</p>	<p>satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per visit is satisfied]</p>
<p>[11.] Hospice Care</p>			
<p align="center">[Prior Authorization Requirement]</p> <p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p>[In addition, [¹for Non-Network Benefits,] you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]</p>			
	<p>Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per day]</p> <p>Non-Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 -</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per day is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 -</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Designated Network facility will be reduced to \$[0 - 1,000]. [The maximum reduction in Copayments is \$[10 - 1,000].]</p> <ul style="list-style-type: none"> [The Coinsurance you pay for the facility charge [and Physician's fees] for services provided at a Designated Network facility will be reduced to [0 - 50]% or \$[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of \$[10 - 1,000].] <p>[You can determine the specific surgical procedures or diagnoses for which enhanced Benefits are available by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p> <p>[[For Network Benefits, ventricular] [Ventricular] assist device implantation services must be received at a Designated Facility.]</p> <p>[Non-Network Benefits for ventricular assist device implantation are limited to \$[30,000 - 250,000] per implantation.]</p>	<p>Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 10,000] per Inpatient Stay]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	of \$[100 - 10,000] per Inpatient Stay]		
[13]. [Infertility Services]			
[Prior Authorization Requirement] [You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
[Limited to \$[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [This limit includes Benefits for infertility medications provided under the <i>Outpatient Prescription Drug Rider.</i>] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under <i>Physician's Office Services - Sickness and Injury</i> below.]	[Designated Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
	[Non-Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No]
[14.] Lab, X-Ray and Diagnostics - Outpatient			
[Prior Authorization Requirement] <i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i> [[¹ For Non-Network Benefits for] [² For] sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
Lab Testing - Outpatient:	[Designated Network] [[50 - 100]%]	[Yes] [No]	[Yes] [No] [Yes, after the Per

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>[[50 - 100]% at a free-standing lab]</p> <p>[[50 - 100]% at a Hospital-based lab]</p> <p>[[50 - 100]% at a Physician office-based lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a free-standing lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a Hospital-based lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a Physician office-based lab]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at a free-standing lab]</p> <p>[[50 - 100]% at a Hospital-based lab]</p> <p>[[50 - 100]% at a Physician office-based lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a</p>	<p>[Yes] [No]</p>	<p>Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>X-Ray and Other Diagnostic Testing - Outpatient:</p>	<p>free-standing lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a Hospital-based lab]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a Physician office-based lab]</p> <p>Non-Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[Designated Network]</p> <p>[[50 - 100]%</p> <p>[[50 - 100]% at a free-standing diagnostic center]</p> <p>[[50 - 100]% at an outpatient Hospital-based diagnostic center]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at a free-standing diagnostic center]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service at an outpatient Hospital-</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>500] per service]</p> <p>[100% after you pay a Copayment of \$[25 - 500] per service at a free-standing diagnostic center]</p> <p>[100% after you pay a Copayment of \$[25 - 500] per service at an outpatient Hospital-based diagnostic center]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[25 - 500] per service]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 500] per service is satisfied]</p>

Include for groups that purchase Mental Health benefits.

[Include as standard for groups of 2 to 15]

¹*Include if group purchases SA benefits.*

[16.] Mental Health Services

[Prior Authorization Requirement]

¹*Include when network providers are responsible for prior authorization for network benefits.* ²*Include when covered person is responsible for prior authorization for network benefits.*

[[¹For Non-Network Benefits for] [²For] a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, [¹for Non-Network Benefits] you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Expenses.]			
<p><i>[Limits will not apply to groups of 51+.]</i></p> <p><i>[Inpatient Mental Health Services are limited to [10 - 100] days per year.]</i></p> <p><i>[Outpatient Mental Health Services are limited to [10 - 100] visits per year.]</i></p> <p><i>[Non-Network Benefits for inpatient Mental Health Services are limited to [10 - 100] days per year.]</i></p> <p><i>[Non-Network Benefits for outpatient Mental Health Services are limited to [10 - 100] visits per year.]</i></p> <p><i>[Benefits for any combination of Mental Health Services described in this section and Neurobiological Disorders - Autism Spectrum Disorder Services described below are limited as follows:</i></p> <ul style="list-style-type: none"> <i>• [10 - 100] days per year for inpatient Mental Health Services and Neurobiological Disorders - Autism Spectrum Disorder Services.</i> <i>• [10 - 100] visits per year for outpatient Mental Health Services and Neurobiological Disorders - Autism Spectrum Disorder Services.]</i> <p><i>[Benefits for any combination of Mental Health Services described in this section and Substance Use Disorder Services described below are</i></p>	<p><i>[Network]</i></p> <p><i>[Inpatient]</i></p> <p><i>[[50 - 100]%]</i></p> <p><i>[100% after you pay a Copayment of \$[100 - 1,000] per day]</i></p> <p><i>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</i></p> <p><i>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</i></p> <p><i>[Outpatient]</i></p> <p><i>[[50 - 100]%]</i></p> <p><i>[100% after you pay a Copayment of \$[5 - 100] per visit]</i></p> <p><i>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</i></p> <p><i>[100% for visits for medication management]</i></p> <p><i>[Non-Network]</i></p> <p><i>[Inpatient]</i></p>	<p><i>[Yes] [No]</i></p> <p><i>[Yes] [No]</i></p> <p><i>[Yes] [No]</i></p> <p><i>[Yes] [No]</i></p>	<p><i>[Yes] [No]</i></p> <p><i>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</i></p> <p><i>[Yes] [No]</i></p> <p><i>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</i></p> <p><i>[Yes] [No]</i></p> <p><i>[Yes, after the Per</i></p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] <p>[Benefits for any combination of <i>Mental Health Services</i> described in this section and <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i> and <i>Substance Use Disorder Services</i> described below are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services, Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services, Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] 	<p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p>[Outpatient]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p>	<p>Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>
<p>[17.] [Neurobiological Disorders - Autism Spectrum Disorder Services]</p>	<p>[Prior Authorization Requirement]</p>		
<p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[[¹For Non-Network Benefits for] [²For] a scheduled admission for Neurobiological Disorders - Autism</p>			

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Spectrum Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, [¹for Non-Network Benefits] you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management[; Applied Behavioral Analysis].</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
<p>[Limits will not apply to groups of 51+.]</p> <p>[Inpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] days per year.]</p> <p>[Outpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] visits per year.]</p> <p>[Non-Network Benefits for inpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] days per year.]</p> <p>[Non-Network Benefits for outpatient Neurobiological Disorders - Autism Spectrum Disorder Services are limited to [10 - 100] visits per year.]</p> <p>[Benefits for any combination of Neurobiological Disorders - Autism Spectrum Disorder Services described in this section and Mental Health Services described above are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient Neurobiological Disorders - Autism Spectrum Disorder Services and Mental Health Services. 	<p>[Network]</p> <p>[Inpatient]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p>[Outpatient]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<ul style="list-style-type: none"> [10 - 100] visits per year for outpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services and Mental Health Services.</i> <p>[Benefits for any combination of <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i> described in this section, <i>Mental Health Services</i> described above and <i>Substance Use Disorder Services</i> described further below are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services, Mental Health Services and Substance Use Disorder Services.</i> [10 - 100] visits per year for outpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services, Mental Health Services and Substance Use Disorder Services.</i> 	<p>[Non-Network]</p> <p><i>[Inpatient]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p> <p><i>[Outpatient]</i></p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>

[18.] [Obesity Surgery]

[Prior Authorization Requirement]

¹Include when network providers are responsible for prior authorization for network benefits. ²Include

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<i>when covered person is responsible for prior authorization for network benefits.]</i>			
<p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p>[In addition, [¹for Non-Network Benefits] you must contact us 24 hours before admission for an Inpatient Stay.]</p> <p>[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]</p>			
<p>[[Any combination of] [Designated Network Benefits] [[,] [and] [Network Benefits] [and Non-Network] Benefits [is] [are] limited to \$[40,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy. [Non-Network Benefits are further limited to \$[5,000 - 30,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]]</p> <p>[Non-Network Benefits include services provided at a Network facility that is not a Designated Facility and services provided at a non-Network facility.]</p>	<p>[Designated Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p> <p>[Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p> <p>[Non-Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>		
[19.] [Ostomy Supplies]			
[Limited to \$[500 - 25,000] per year.]	<p>[Network]</p> <p>[[50 - 100]%</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per item is</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>[Non-Network] [[50 - 100]%]</p>	[Yes] [No]	<p>satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per item is satisfied]</p>
[20.] Pharmaceutical Products - Outpatient			
[Prior Authorization Requirement]			
<p>¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</p>			
<p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before scheduled intravenous infusions are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
<p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses. You may determine whether a particular Pharmaceutical Product requires prior authorization through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>			
<p>[The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Pharmaceutical Product, unless adjusted based on the manufacturer's packaging size, or based on supply limits. <p>When a Pharmaceutical Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.]</p>	<p>[Designated Network] [[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[0 - 75] per Tier 1 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[15 -</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per Pharmaceutical Product is satisfied]</p> <p>[Yes, except when provided during a Physician office visit]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>250] per Tier 2 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[20 - 450] per Tier 3 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[70 - 650] per Tier 4 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[100 - 750] per Tier 5 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[150 - 850] per Tier 6 Pharmaceutical Product]</p> <p>[[50 - 100]% - Tier 1]</p> <p>[[50 - 100]% - Tier 2]</p> <p>[[50 - 100]% - Tier 3]</p> <p>[[50 - 100]% - Tier 4]</p> <p>[[50 - 100]% - Tier 5]</p> <p>[[50 - 100]% - Tier 6]</p> <p>Network</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[0 - 75]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per Pharmaceutical Product is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>per Tier 1 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[15 - 250] per Tier 2 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[20 - 450] per Tier 3 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[70 - 650] per Tier 4 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[100 - 750] per Tier 5 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[150 - 850] per Tier 6 Pharmaceutical Product]</p> <p>[[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]</p> <p>Non-Network [[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 -</p>	<p>[Yes] [No]</p>	<p>[Yes, except when provided during a Physician office visit]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>100] per Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[0 - 75] per Tier 1 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[15 - 250] per Tier 2 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[20 - 450] per Tier 3 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[70 - 650] per Tier 4 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[100 - 750] per Tier 5 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[150 - 850] per Tier 6 Pharmaceutical Product]</p> <p>[[50 - 100]% - Tier 1]</p> <p>[[50 - 100]% - Tier 2]</p> <p>[[50 - 100]% - Tier 3]</p> <p>[[50 - 100]% - Tier 4]</p> <p>[[50 - 100]% - Tier 5]</p> <p>[[50 - 100]% - Tier 6]</p>		<p>Deductible of \$[5 - 100] per Pharmaceutical Product is satisfied]</p> <p>[Yes, except when provided during a Physician office visit]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[21.] Physician Fees for Surgical and Medical Services			
<p>[When you choose to seek care [as a result of certain diagnoses or] from Designated Network Physicians as identified below, your Benefits will be enhanced as described:]</p> <p>[Specialties:]</p> <ul style="list-style-type: none"> • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we provide designation.] 	<p>[Designated Network] [[50 - 100]%</p> <p>Network [50 - 100]%</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[50 - 250] per service is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[50 - 250] per service is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[Enhanced Benefits:]</p> <ul style="list-style-type: none"> [The Coinsurance you pay for Physician's Fees from a Designated Network Physician will be reduced to [0 - 50]% or \$[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of \$[10 - 1,000].] <p>[You can determine the specific services for which enhanced Benefits are available by going to [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.]</p> <p>[Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Non-Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.]</p> <p>[Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.]</p>	<p>Non-Network</p> <p>[50 - 100]%</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[50 - 250] per service is satisfied]</p>
<p>[22.] Physician's Office Services - Sickness and Injury</p>			

[Prior Authorization Requirement]

¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]

[¹For Non-Network Benefits you] [²You] must obtain prior authorization as soon as is reasonably possible before [Genetic Testing - BRCA] [Genetic Testing, including BRCA Genetic Testing] is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[When you choose to seek care [as a result of certain diagnoses or] from Designated Network Physicians as identified below, your Benefits will be enhanced as described:]</p> <p>[Specialties:]</p> <ul style="list-style-type: none"> • [Cardiology.] • [Cardiac/Cardio-thoracic Surgery.] • [Orthopedic Surgery.] • [Neurosurgery.] • [Allergy.] • [Nephrology.] • [Neurology.] • [Oncology.] • [Pulmonology.] • [Rheumatology.] • [Endocrinology.] • [Infectious Disease.] • [Gastroenterology.] • [Obstetrics/Gynecology.] • [Reproductive Endocrinology.] • [All specialties for which we 	<p>[\$5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for allergy injections when no other service is provided during the office visit]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>provide designation.]</p> <p>[Enhanced Benefits:]</p> <ul style="list-style-type: none"> [The Copayment you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to \$[0 - 1,000]. [The maximum reduction in Copayments is \$[10 - 1,000].]] [The Coinsurance you pay for [the initial office visit] [the first [1 - 100] office visit(s)] provided by a Designated Network Physician will be reduced to [0 - 50]% or \$[10 - 1,000] will be applied toward any applicable Annual Deductible if not already met, to a maximum of \$[10 - 1,000].] <p>[You can determine the specific specialties for which enhanced Benefits are available by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p> <p>[In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office:</p> <ul style="list-style-type: none"> [Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient.</i>] [Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and</i> 	<p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for allergy injections when no other service is provided during the office visit]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<ul style="list-style-type: none"> • <i>Nuclear Medicine - Outpatient.</i>] [Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient.</i>] • [Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>] • [Outpatient surgery procedures described under <i>Surgery - Outpatient.</i>] • [Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i>] • [Rehabilitation therapy procedures described under <i>Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment].</i>] 	<p>Physician office visit; [50 - 100]% for a Specialist Physician office visit</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for allergy injections when no other service is provided during the office visit]</p>		
<p>¹Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude. ²If Maternity Services are excluded, Complications of Pregnancy</p>			

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>must always be included.]</i></p> <p>[23.] Pregnancy - [1]Maternity Services] [2]Complications of Pregnancy only]</p>			
<p><i>[Include when benefits are provided for maternity services.]</i></p>			
<p>[Prior Authorization Requirement]</p>			
<p><i>[1]Include when network providers are responsible for prior authorization for network benefits. 2]Include when covered person is responsible for prior authorization for network benefits.]</i></p>			
<p><i>[[1]For Non-Network Benefits you] [2]You] must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</i></p>			
<p><i>[Include when benefits are provided for complications of pregnancy only.]</i></p>			
<p>[Prior Authorization Requirement]</p>			
<p><i>[1]Include when network providers are responsible for prior authorization for network benefits. 2]Include when covered person is responsible for prior authorization for network benefits.]</i></p>			
<p><i>[[1]For Non-Network Benefits you] [2]You] must obtain prior authorization five business days before admission for scheduled admissions or within one business day or the same day, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</i></p>			
<p>It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.</p>			
	<p><i>[Include when benefits are provided for maternity services. Bracketed text within is plan design variable.]</i></p> <p>[Network]</p> <p><i>[Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits [except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]]</i></p> <p>[Non-Network]</p> <p><i>[Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits [except that</i></p>		

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]]</p> <p><i>[Include when benefits are provided for complications of pregnancy only.]</i></p> <p>[Network] [Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p> <p>[Non-Network] [Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p>		
[24.] Preventive Care Services			
<p>Physician office services</p> <ul style="list-style-type: none"> Well baby and well child care includes, but is limited to, 20 visits at approximately the following age intervals: birth, two weeks, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, three years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years. <p>No Copayment, Coinsurance or deductible will be applicable to Network or non-Network children's immunizations.</p>	<p>Network 100%</p> <p>Non-Network [[50 - 100]%) [100% after you pay a Copayment of \$[5 - 100] per visit] [100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]%) for a Specialist Physician office visit] [100% for a Primary Physician office visit; [50 - 100]%) for a</p>	<p>No</p> <p>[Yes] [No] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available except for children under the age of 19.].]</p>	<p>No</p> <p>[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied] [Yes, when Benefits are subject to Coinsurance] [Non-Network Benefits are not available except for children under the age of 19.].]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Lab, X-ray or other preventive tests</p>	<p>Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for immunizations when no other service is provided during the office visit.]</p> <p>[Non-Network Benefits are not available.]</p> <p>Network 100%</p> <p>Non-Network [[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per service]</p>	<p>No</p> <p>[Yes] [No]</p>	<p>No</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]</p>
<p><i>Prosthetics are a mandated benefit in Arkansas.</i></p> <p>[25.] Prosthetic Devices and Services</p>	<p align="center">[Prior Authorization Requirement]</p>		
<p><i>¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[¹For Non-Network Benefits you] [²You] must obtain prior authorization before obtaining prosthetic devices [that exceed \$[1,000 - 5,000] in cost per device]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>Benefits for replacement are limited to a single purchase of each type of</p>	<p>[Network]</p>		

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
prosthetic device every three years Benefits for replacement are limited to a single purchase of each type of prosthetic device every three years	[[50 - 100]%] [Non-Network] [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
[26.] Reconstructive Procedures			
<p style="text-align: center;">Prior Authorization Requirement</p> <p><i>¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, [¹for Non-Network Benefits] you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]</p>			
	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]</i></p> <p>[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]</i></p> <p>[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to</p>		

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	the Out-of-Pocket Maximum.]]		
[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]			
[Prior Authorization Requirement]			
<p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p>			
<p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy] or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
<p>[Limited per year as follows:</p> <ul style="list-style-type: none"> • [[10 -100] visits of physical therapy.] • [[10 -100] visits of occupational therapy.] • [[10 -100] Manipulative Treatments.] • [[10 -100] visits of speech therapy.] • [[10 -100] visits of pulmonary rehabilitation therapy.] • [[10 -100] visits of cardiac rehabilitation therapy.] • [[10 -100] visits of post-cochlear implant aural therapy.] • [[10 - 100] visits of cognitive rehabilitation therapy.] • [[10 -100] visits of vision therapy.]] <p>[Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy,</p>	<p>[Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[Non-Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, when</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] is limited to [10 - 160] visits per year.]</p> <p>[Network Benefits for any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] are limited to [10 - 160] visits per year.]</p> <p>[Non-Network Benefits for any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] are limited to [10 - 160] visits per year.]</p>	<p>Copayment of \$[5 - 100] per visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p>	<p>Benefits are subject to Coinsurance]</p>	<p>Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>
<p>[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic</p>	<p align="center">[Prior Authorization Requirement]</p>		
<p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
	<p>[Designated Network]</p> <p>[[50 - 100]%</p> <p>[[50 - 100]% at a free-standing center]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>[[50 - 100]% at an outpatient Hospital-based center]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at a free-standing center]</p> <p>[[50 - 100]% at an outpatient Hospital-based center]</p> <p>Non-Network</p> <p>[50 - 100]%</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>
<p>[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</p>	<p align="center">Prior Authorization Requirement</p> <p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[[¹For Non-Network Benefits for] [²For] a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, [¹for Non-Network Benefits] you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>		
<p>[Limited to [40 - 180] days per year.]</p> <p>[Limited to:</p> <ul style="list-style-type: none"> • [30 - 180] days per year in a Skilled Nursing Facility. • [30 - 180] days per year in an Inpatient Rehabilitation Facility.] <p>[Network Benefits are limited to [40 - 180] days per year. Non-Network Benefits are limited to [40 - 180] days per year.]</p>	<p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[50 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[50 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[50 -</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[50 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>1,000] per day to a maximum Copayment of \$[50 - 5,000] per Inpatient Stay]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[50 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[50 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[50 - 1,000] per day to a maximum Copayment of \$[50 - 10,000] per Inpatient Stay]</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[50 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>
<p><i>[Include as standard for groups of 2 to 15]</i></p> <p>[30.] Substance Use Disorder Services</p>	[Prior Authorization Requirement]		
<p><i>[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</i></p> <p>[[¹For Non-Network Benefits for] [²For] a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, [¹for Non-Network Benefits] you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
<p><i>[Limits will not apply to groups of 51+.]</i></p> <p>[Inpatient Substance Use Disorder</p>	[Network]		

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Services are limited to [10 - 100] days per year.]</p> <p>[Outpatient <i>Substance Use Disorder Services</i> are limited to [10 - 100] visits per year.]</p> <p>[Non-Network Benefits for inpatient <i>Substance Use Disorder Services</i> are limited to [10 - 100] days per year.]</p> <p>[Non-Network Benefits for outpatient <i>Substance Use Disorder Services</i> are limited to [10 - 100] visits per year.]</p> <p>[Benefits for any combination of <i>Substance Use Disorder Services</i> described in this section and <i>Mental Health Services</i> described above are limited as follows:</p> <ul style="list-style-type: none"> • [10 - 100] days per year for inpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. • [10 - 100] visits per year for outpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] 	<p>[Inpatient]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day]</p> <p>[100% after you pay a Copayment of \$[100 - 2,000] per Inpatient Stay]</p> <p>[100% after you pay a Copayment of \$[100 - 1,000] per day to a maximum Copayment of \$[100 - 5,000] per Inpatient Stay]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>
<p>[Benefits for any combination of <i>Substance Use Disorder Services</i> described in this section and <i>Mental Health Services</i> and <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i> described above are limited as follows:</p> <ul style="list-style-type: none"> • [10 - 100] days per year for inpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. • [10 - 100] visits per year for outpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance</i> 	<p>[Outpatient]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>insertion] [,] [and] [pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgery]] you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at an ambulatory surgical center]</p> <p>[[50 - 100]% at an outpatient Hospital-based surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service at an ambulatory surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service at an outpatient Hospital-based surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[10 - 1,000] per date of service is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>[When you choose to seek care from Designated Network facilities for certain surgical procedures, your Benefits will be enhanced as follows:]</p> <ul style="list-style-type: none"> [The Copayment you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [\$0 - 1,000]. [The maximum reduction in Copayments is \$[10 - 1,000].]] [The Coinsurance you pay for the facility charge [and Physician's fees] for outpatient surgery provided at a Designated Network facility will be reduced to [0 - 50]% or \$[10 - 1,000] will be applied toward any applicable deductible if not already met, to a maximum of \$[10 - 1,000].] <p>[You can determine the specific surgical procedures for which enhanced Benefits are available by going to [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>	<p>Copayment of \$[10 - 5,000] per year at an ambulatory surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year at an outpatient Hospital-based surgical center]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at an ambulatory surgical center]</p> <p>[[50 - 100]% at an outpatient Hospital-based surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service at an ambulatory surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service at an outpatient Hospital-based surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 -</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[10 - 1,000] per date of service is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>5,000] per year]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year at an ambulatory surgical center]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year at an outpatient Hospital-based surgical center]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service]</p> <p>[100% after you pay a Copayment of \$[10 - 1,000] per date of service, to a maximum Copayment of \$[10 - 5,000] per year]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[10 - 1,000] per date of service is satisfied]</p>
<p>[32.] Temporomandibular Joint Services</p>			

[Prior Authorization Requirement]

[¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]

[[¹For Non-Network Benefits you] [²You] must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]

[In addition, [¹for Non-Network Benefits] you must contact us 24 hours before admission for scheduled

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
inpatient admissions.]			
[Limited to \$[1,000 - 20,000] per year.]	<p>[Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p> <p>[Non-Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p>		
[33.] Therapeutic Treatments - Outpatient	[Prior Authorization Requirement]		
<p>¹Include when network providers are responsible for prior authorization for network benefits. ²Include when covered person is responsible for prior authorization for network benefits.]</p> <p>[[¹For Non-Network Benefits you] [²You] must obtain prior authorization [for all outpatient therapeutic services] [for the following outpatient therapeutic services] five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [Services that require prior authorization: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound].] If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
	<p>[Designated Network]</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at a free-standing center]</p> <p>[[50 - 100]% at an outpatient Hospital-based center]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment at a free-standing center]</p> <p>[100% after you pay a</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 100] per treatment is satisfied]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Copayment of \$[25 - 100] per treatment at an outpatient Hospital-based center]</p> <p>Network</p> <p>[[50 - 100]%]</p> <p>[[50 - 100]% at a free-standing center]</p> <p>[[50 - 100]% at an outpatient Hospital-based center]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment at a free-standing center]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment at an outpatient Hospital-based center]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[25 - 100] per treatment]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 100] per treatment is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[25 - 100] per treatment is satisfied]</p>
<p>[34.] Transplantation Services</p>	<p>Prior Authorization Requirement</p> <p>For Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid. [Non-Network Benefits will apply.]</p> <p>[For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant</p>		

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p> <p><i>[¹Include when network providers are responsible for prior authorization for network benefits.]</i></p> <p>[In addition, [¹for Non-Network Benefits] you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>			
<p>For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.</p> <p>[Non-Network Benefits are limited to \$[30,000 - 250,000] per transplant.]</p>	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>		
<p>[35.] Urgent Care Center Services</p>			
<p>[Limited to [2 - 10] visits per year.]</p> <p>[In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center:</p> <ul style="list-style-type: none"> [Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient</i>.] [Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</i>.] [Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products -</i> 	<p>Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit to a maximum Copayment of \$[5 - 5,000] per year]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit for the</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 150] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Outpatient.]</i></p> <ul style="list-style-type: none"> • [Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>] • [Outpatient surgery procedures described under <i>Surgery - Outpatient.</i>] • [Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i>] • [Rehabilitation therapy procedures described under <i>Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment].]</i>] 	<p>first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>Non-Network</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit to a maximum Copayment of \$[5 - 5,000] per year]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 150] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 150] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	that year]		
[36.] [Vision Examinations]			
<p>[Limited to [1 exam] [[2-3] exams] per year.]</p> <p>[Limited to [1 exam] [[2-3] exams] every [2 - 3] years.]</p>	<p>[Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[Non-Network]</p> <p>[[50 - 100]%</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit]</p> <p>[100% after you pay a</p>	<p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p> <p>[Yes, when Benefits are subject to Coinsurance]</p>

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit [100% for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit]		
[37.] [Wigs]			
[Limited to \$[100 - 1,000] per year.] [Limited to \$[100 - 5,000] every [24 - 36] months.]	[Network] [[50 - 100]%] [Non-Network] [[50 - 100]%]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]
Additional Benefits Required By Arkansas Law			
[38.] Dental Services - Anesthesia and Hospitalization			
<p style="text-align: center;">Pre-service Notification Requirement</p> <p style="text-align: center;">Any applicable notification requirements will be the same as those stated under each Covered Health Service Category in this <i>Schedule of Benefits</i>.</p>			
	Network [Benefits will be the same as those stated under each Covered Health Service Category in this <i>Schedule of Benefits</i> .] Non-Network [Benefits will be the same as those stated under each Covered Health Service Category in this <i>Schedule of Benefits</i> .]		
[39.] In Vitro Fertilization Services			
¹ Include applicable reduction in Benefits or no Benefits.			
Pre-service Notification Requirement			

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>You must notify us as soon as the possibility of the need for in vitro fertilization arises. If you fail to notify us as required, [¹Benefits will be reduced to [50 - 95]% of Eligible Expenses] [¹you will be responsible for paying all charges and no Benefits will be paid].</p>			
<p>Limited to a lifetime maximum of \$15,000.</p>	<p>Network [Benefits will be the same as those stated under each Covered Health Service Category in this <i>Schedule of Benefits</i>.]</p> <p>Non-Network [Benefits will be the same as those stated under each Covered Health Service Category in this <i>Schedule of Benefits</i>.]</p>		
<p>[40.] Medical Foods</p>			
<p>¹Include applicable reduction in Benefits or no Benefits.</p>			
<p align="center">Pre-service Notification Requirement</p> <p>You must notify us as soon as the possibility of the need for in vitro fertilization arises. If you fail to notify us as required, [¹Benefits will be reduced to [50 - 95]% of Eligible Expenses] [¹you will be responsible for paying all charges and no Benefits will be paid].</p>			
	<p>Network [50 - 100]%</p> <p>Non-Network Same as Network</p>	<p>[Yes] [No]</p> <p>Same as Network</p>	<p>Network [50 - 100]%</p> <p>Non-Network Same as Network</p>
<p><i>Mandated offer in Arkansas.</i></p>			
<p>[[41.] Musculoskeletal Disorders of the Face, Neck or Head]</p>			
<p align="center">[Pre-service Notification Requirement]</p> <p>[Depending upon where the Covered Health Service is provided, any applicable notification or authorization requirements will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>			
<p align="center">[¹ Designated Network]</p> <p>[Depending upon where the Covered Health Service is</p>			

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

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

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i></p> <p>[Network]</p> <p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits.</i>]</p>		
<p>[[42.] Orthotic Devices and Services</p>			
<p><i>Include if notification is required.</i></p> <p>¹<i>Include when notification applies only to orthotics that exceed a minimum dollar amount and insert applicable dollar amount.</i></p> <p>²<i>Include applicable reduction in Benefits or no Benefits.</i></p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[For Non-Network Benefits you must notify us before obtaining orthotic devices [¹that exceed \$[1,000 - 5,000] in cost per device]. If you fail to notify us as required, [²Benefits will be reduced to [50 - 95]% of Eligible Expenses] [²you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>Benefits for replacements are limited to a single purchase of each type of orthotic device every three years.</p>	<p>Network</p> <p>[50 - 100%]</p> <p>Non-Network</p> <p>[50 - 100%]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes] [No]</p>

Eligible Expenses

¹Include if non-network RAPLs and consultants at a network facility are paid as network benefits at less than billed charges.]

Eligible Expenses are the amount we determine that we will pay for Benefits. For [Designated Network Benefits and] Network Benefits [¹for Covered Health Services provided by a Network provider], you are not responsible for any difference between Eligible Expenses and the amount the provider bills. [¹For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by us), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below.] For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

[Include if plan includes ability to determine alternate levels of benefits.]

[If one or more alternative health services that meets the definition of a Covered Health Service in the *Certificate* under *Section 9: Defined Terms* are clinically appropriate and not more costly than an alternative health service that is at least as likely to produce equivalent therapeutic or diagnostic results as to their prevention, diagnosis or treatment of a Sickness, Injury, [Mental Illness,] [mental illness,] substance use disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on *Generally Accepted Standards of Medical Practice*, which for some Covered Health Services may be addressed in our clinical policies.]

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

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

[Include if RAPLs and consultants are paid as network benefits at less than billed charges.]

- [For Covered Health Services received at a Network facility on a non-Emergency basis from a [radiologist] [,] [and] [anesthesiologist] [,] [and] [pathologist] [,] [and] [consulting Physician] [,] [and] [neonatologist] [,] [and] [intensivist] [,] [and] [assistant surgeon] [and] [surgical assistant], the Eligible Expense is based on [[110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market] [50 - 100]% of the provider's billed charge].

When a rate is not published by *CMS* for the service, we use 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, Inc.* If the *Ingenix, Inc.* relative value scale becomes no longer available, a comparable scale will be used. We and *Ingenix, Inc.* are related companies through common ownership by *UnitedHealth Group*.

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 Eligible Expense is based on 50% of the provider's billed charge.]

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

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:

[PHCS payment option.]

[¹Include if RAPLs and consultants are paid as non-network benefits.]

- [Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.
- If rates have not been negotiated, then one of the following amounts:
 - ◆ For Covered Health Services other than Pharmaceutical Products [¹and services from the specific providers identified below], Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.

[²Include when benefits are provided for either Mental Health Services or Substance Use Disorder Services.]

If no fee information is available for a Covered Health Service, the Eligible Expense is based on [50 - 100]% of the provider's billed charge², except that certain Eligible Expenses for [Mental Health Services] [and] [Substance Use Disorder Services] are based on 80% of the billed charge.]

- ◆ ²For [Mental Health Services] [and] [Substance Use Disorder Services] the Eligible Expense will be reduced by [5 - 30]% for Covered Health Services provided by a psychologist and by [5 - 40]% for Covered Health Services provided by a masters level counselor.]

- ◆ When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [110 - 200]% 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.

When a rate is not published by *CMS* for the service we use 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.

- ◆ ¹For Covered Health Services received on a non-Emergency basis from a [radiologist] [,] [and] [anesthesiologist] [,] [and] [pathologist] [,] [and] [consulting Physician] [,] [and] [neonatologist] [,] [and] [intensivist] [,] [and] [assistant surgeon] [and] [surgical assistant], the Eligible Expense is based on [[110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market] [50 - 100]% of the provider's billed charge].

When a rate is not published by *CMS* for the service, we use 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, Inc.* If the *Ingenix, Inc.* relative value scale becomes no longer available, a comparable scale will be used. We and *Ingenix, Inc.* are related companies through common ownership by *UnitedHealth Group.*]

[MNRP payment option.]

- [Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.
- If rates have not been negotiated, then one of the following amounts:

¹Include if RAPLs and consultants are paid as non-network benefits.]

- ◆ ¹Except for services from the specific providers identified below,] Eligible Expenses are determined based on [110 - 200]% 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.
- ◆ ¹For Covered Health Services received on a non-Emergency basis from a [radiologist] [,] [and] [anesthesiologist] [,] [and] [pathologist] [,] [and] [consulting Physician] [,] [and] [neonatologist] [,] [and] [intensivist] [,] [and] [assistant surgeon] [and] [surgical assistant], the Eligible Expense is based on [[110 - 200]% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market] [50 - 100]% of the provider's billed charge].]
- ◆ When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
 - ▶ For services other than Pharmaceutical Products, we use 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, Inc.* If the *Ingenix, Inc.* relative value scale becomes no

longer available, a comparable scale will be used. We and *Ingenix, Inc.* are related companies through common ownership by *UnitedHealth Group*.

- ▶ For Pharmaceutical Products, we use 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.

^[2]Include when benefits are provided for either *Mental Health Services* or *Substance Use Disorder Services*.]

- ◆ 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 Eligible Expense is based on 50% of the provider's billed charge^[2], except that certain Eligible Expenses for [*Mental Health Services*] [and] [*Substance Use Disorder Services*] are based on 80% of the billed charge.
- ◆ ^[2]For [*Mental Health Services*] [and] [*Substance Use Disorder Services*] the Eligible Expense will be reduced by [5 - 30]% for Covered Health Services provided by a psychologist and by [5 - 40]% for Covered Health Services provided by a masters level counselor.]

We update the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.]

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

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses at our discretion.

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

You or your Network Physician must notify us of special service needs (such as transplants, [ventricular assist device implantation](#)) or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

UnitedHealthcare [Non-Differential PPO]

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

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

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

^[1] *Include when shared savings program applies.*

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

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

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

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

Prior Authorization

We require prior authorization for certain Covered Health Services. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

When you choose to receive certain Covered Health Services, you are responsible for obtaining prior authorization before you receive these services. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

To obtain prior authorization, call the telephone number for *Customer Care* on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to determine how far in advance you must obtain prior authorization.

[Include bracketed variable benefit category listed below if: a) the benefit is included in the plan design and b) prior authorization is required. Include dollar amounts as applicable.]

- [_____]
- Ambulance - non-emergent air and ground.
- Clinical trials.
- [Congenital heart disease surgery.]
- [Dental services - accidental.]
- Dental services - anesthesia and hospitalization and ambulatory surgery.
- [Diabetes equipment - insulin pumps [over \$[1,000 - 5,000]].]
- [Durable Medical Equipment [over \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)].]
- [Medical Foods.]

[Include when prior authorization is required for only BRCA genetic testing.]

- [Genetic Testing - BRCA.]

[Include when prior authorization is required for all genetic testing.]

- [Genetic Testing, including BRCA Genetic Testing.]
- [Hearing aids [that exceed \$[1,000 - 5,000] in retail purchase cost].]
- [Home health care.]
- [Hospice care - inpatient.]
- Hospital inpatient care - all scheduled admissions [and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery].
- [Infertility services.]
- In vitro fertilization services.
- [Lab, X-ray and diagnostics - sleep studies.]
- [Lab, X-ray and major diagnostics - CT, PET Scans, MRI, MRA, Nuclear Medicine and Capsule Endoscopy.]

Include when group purchases benefits for musculoskeletal disorders.

- [Musculoskeletal disorders of the face neck or head.]
- [Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.]
- [Neurobiological disorders - Autism Spectrum Disorder services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond

45 - 50 minutes in duration, with or without medication management[; Applied Behavioral Analysis (ABA)].]

- [Obesity surgery.]

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

- Orthotics devices [¹over\$[1,000-5,000]].
- [Pain management.]
- [Pharmaceutical Products - IV infusions only.]
- [Certain Pharmaceutical Products. You may determine whether a particular Pharmaceutical Product requires authorization through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

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

- Prosthetic devices [¹over \$[1,000 - 5,000]].]
- Reconstructive procedures, including breast reconstruction surgery following mastectomy [and breast reduction surgery].
- [Rehabilitation services [and Manipulative Treatment] - [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy].]
- [Scopic procedures - outpatient diagnostic and therapeutic.]
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- [Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.]

¹Do not include pain management procedures if prior authorization is required for all pain management services above.]

- [Surgery - [all outpatient surgeries] [only for the following outpatient surgeries: [blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [¹pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgeries]].]
- [Temporomandibular joint services.]
- [Therapeutics - [all outpatient therapeutics] [only for the following services: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound]].]
- Transplants.
- [Ventricular assist device implantation. You must obtain prior authorization as soon as the possibility of implantation arises except in cases of Emergency implantations of partial assist devices.]

[Include paragraph below if plan includes ability to determine alternate levels of benefits.]

[Here and throughout the document, include defined capitalized term if Mental Health Benefits are sold; include lower case reference if Mental Health Benefits are not sold.]

[As we determine, if one or more alternative health services that meets the definition of a Covered Health Service in the *Certificate* under *Section 9: Defined Terms* are clinically appropriate and not more costly than an alternative health service that is at least as likely to produce equivalent therapeutic or diagnostic results as to their prevention, diagnosis or treatment of a Sickness, Injury, [Mental Illness,] [mental illness,] substance use disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on *Generally Accepted Standards of Medical Practice*, which for some Covered Health Services may be addressed in our clinical policies. After you contact us for prior authorization, we will identify the Benefit level available to you.

These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.]

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

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a [calendar] [Policy] year basis.

Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.

[The Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

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

Payment Term And Description	Amounts
Annual Deductible	
<p><i>[Annual deductible is plan design variable. Include applicable provisions to support the following:</i></p> <p>¹<i>Outpatient Prescription Drug Rider is sold and the annual deductible applies to any combination of medical and RX benefits.</i></p> <p>²<i>Outpatient Prescription Drug Rider with separate copayments for preventive medications is sold and the annual deductible does not apply to preventive medications.</i></p> <p>³<i>Outpatient Prescription Drug Rider is sold and when the annual deductible does not apply to insulin, diabetic supplies, or both. Modify to address which are not subject to payment of the annual deductible.</i></p> <p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. [¹The Annual Deductible applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>. [²Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.]] [³Benefits for [insulin] [diabetic supplies] [insulin and diabetic supplies] under the <i>Outpatient Prescription Drug Rider</i> are not subject to payment of the Annual Deductible.]</p> <p><i>[Include applicable provisions to support the following:</i></p> <p>¹<i>Day/visit limits are reduced by the number of days/visit used toward meeting the deductible.</i></p> <p>²<i>Carry-over provision applies.</i></p> <p>³<i>Roll-over provision applies in any circumstance.</i></p> <p>⁴<i>Roll-over provision applies only to groups changing from calendar to policy year. ⁵Include when roll-over applies only to the individual deductible.</i></p> <p>⁶<i>Include only when a per occurrence deductible applies.]</i></p> <p>[¹Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.]</p> <p>[²Any amount you pay for medical expenses in the last three months of the previous year that is applied to the previous Annual Deductible will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.]</p> <p>[³When a Covered Person was previously covered under a</p>	<p>[For single coverage, the Annual Deductible is \$[0 - 15,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is \$[0 - 45,000]. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.]</p> <p>[\$[0 - 15,000] per Covered Person.]</p> <p>[\$[0 - 15,000] per Covered Person, not to exceed \$[0 - 45,000] for all Covered Persons in a family.]</p> <p>[No Annual Deductible.]</p>

Payment Term And Description	Amounts
<p>group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.]</p> <p>[⁴When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year. [⁵This roll-over feature applies only to the individual Annual Deductible.]]</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>[⁶The Annual Deductible does not include any applicable Per Occurrence Deductible.]</p>	
<p>[Per occurrence deductible is plan design variable.]</p> <p>[Per Occurrence Deductible]</p>	
<p>[The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services.</p> <p>You are responsible for paying the lesser of the following:</p> <ul style="list-style-type: none"> • The applicable Per Occurrence Deductible. • The Eligible Expense.] 	<p>[When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.]</p>
<p>Out-of-Pocket Maximum</p>	

Payment Term And Description	Amounts
<p><i>[Out-of-pocket maximum is plan design variable. Include applicable provisions to support the following:</i></p> <p>¹<i>Includes the annual deductible.</i></p> <p>²<i>Includes the per occurrence deductible.</i></p> <p>³<i>Includes copayments.</i></p> <p>⁴<i>Outpatient Prescription Drug Rider is sold and the OOPM applies to any combination of medical and RX benefits.</i></p> <p>The maximum you pay per year for [¹the Annual Deductible,] [²the Per Occurrence Deductible,] [³Copayments] [¹⁻²⁻³or] Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. [⁴The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when plan design does not apply all copayments/coinsurance to the OOPM.]</i></p> <p>[[Copayments] [and] [Coinsurance] for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.] Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> • Any charges for non-Covered Health Services. <p><i>[Include bullet if prior authorization requirements apply to any benefit category in the Schedule of Benefits table and if the plan design supports not applying penalties to the OOPM.]</i></p> <ul style="list-style-type: none"> • [The amount Benefits are reduced if you do not obtain prior authorization as required.] • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the <i>Schedule of Benefits</i> table that does not apply to the Out-of-Pocket Maximum. <p><i>[Include when an Outpatient Prescription Drug Rider is sold and copayments/coinsurance do not apply to the overall OOPM.]</i></p> <ul style="list-style-type: none"> • [Copayments or Coinsurance for Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.] 	<p>[For single coverage, the Out-of-Pocket Maximum is \$[0 - 45,000] per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$[0 - 135,000].]</p> <p>[\$[0 - 45,000] per Covered Person.]</p> <p>[\$[0 - 45,000] per Covered Person, not to exceed \$[0 - 135,000] for all Covered Persons in a family.]</p> <p>[The Out-of-Pocket Maximum includes the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Annual Deductible.]</p> <p>[The Out-of-Pocket Maximum includes the Per Occurrence Deductible.]</p> <p>[The Out-of-Pocket Maximum does not include the Per Occurrence Deductible.]</p> <p>[No Out-of-Pocket Maximum.]</p>
<p><i>[Annual maximum benefit is plan design variable. Include applicable provisions to support the following:</i></p>	

Payment Term And Description	Amounts
<p>¹<i>Outpatient Prescription Drug Rider is sold.</i></p> <p>[Annual Maximum Benefit]</p>	
<p>[The maximum amount we will pay for Benefits during the year.] [¹The Annual Maximum Benefit applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>.]</p>	<p>[\$[2,000 - 2,500,000] per Covered Person.]</p>

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

[For Pharmaceutical Products, your Copayments are determined by the tier to which the Pharmaceutical Product List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

[For Pharmaceutical Products, your Coinsurance is determined by the tier to which the Pharmaceutical Product List Management Committee has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design.]

[Include the following variables according to plan design:

- Benefit limits and levels.*
- Prior authorization requirements and any penalty for failure to prior authorize*

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Air Ambulance: [[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[25 - 10,000] per [transport] [day] is satisfied]
[3.] Clinical Trials			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i> .	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
[4.] [Congenital Heart Disease Surgeries]			
<p style="text-align: center;">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
	[[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]
[5.] [Dental Services - Accident Only]			
<p style="text-align: center;">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
[Limited to \$[2,000 - 5,000] per year. Benefits are further limited to a	[[50 - 100]%	[Yes] [No]	[Yes] [No]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
maximum of \$[500 - 1,500] per tooth.]			[Yes, after the Per Occurrence Deductible of \$[5 - 75] per visit is satisfied]
[6.] Diabetes Services			
<p><i>[¹Include when the durable medical equipment benefit is sold.]</i></p> <p><i>[²Include when the durable medical equipment benefit is not sold.]</i></p> <p style="text-align: center;">Prior Authorization Requirement</p> <p>You must obtain prior authorization before obtaining any [¹Durable Medical Equipment] [²diabetes equipment] for the management and treatment of diabetes [that exceeds \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p>			
<p>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</p> <p>Diabetes Self-Management Items</p> <p>Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under <i>Durable Medical Equipment</i>.</p> <p><i>[Include only when benefits for durable medical equipment are not sold and when benefits for insulin pumps are limited.]</i></p> <p>[Benefits for insulin pumps are limited to \$[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[two-five] years].]</p>	<p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>[Include when both benefits for durable medical equipment and the Outpatient Prescription Drug Rider are sold.]</i></p> <p>[Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when benefits for durable medical equipment are sold, but the Outpatient Prescription Drug Rider is not sold. Bracketed text within is plan design variable.]</i></p> <p>[For diabetes equipment, Benefits will be the same as those stated under <i>Durable Medical Equipment</i>.</p> <p>For diabetes supplies the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p> <p><i>[Include when benefits for durable medical equipment are not sold and the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]</p> <p>Benefits for diabetes supplies will be the same as those stated</p>		

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>in the <i>Outpatient Prescription Drug Rider</i>.]</p> <p><i>[Include when neither benefits for durable medical equipment nor the Outpatient Prescription Drug Rider is sold. Bracketed text within is plan design variable.]</i></p> <p>[For insulin pumps and diabetes supplies, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p>		
[7.] [Durable Medical Equipment]			
<p>[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization before obtaining any Durable Medical Equipment [that exceeds \$[1,000 - 5,000] in cost (either retail purchase cost or cumulative retail rental cost of a single item)]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
<p>[Limited to \$[500 - 100,000] in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two - five] years]. [This limit does not apply to wound vacuums[, which are subject to a separate limit of \$[4,500 - 13,500] per year and limited to a single purchase (including repair/replacement) every [year] [[two - five] years]].]</p> <p>[Limited per year as follows:</p> <ul style="list-style-type: none"> • [\$[500 - 10,000] in Eligible Expenses for Tier 1. Tier 1 includes disposable supplies necessary for the effective use of covered Durable Medical Equipment.] • [\$[10,001 - 25,000] in Eligible Expenses for Tier 2.] • [\$[25,001 - 100,000] in Eligible Expenses for Tier 3.] <p>These Tier limits include repair. Benefits for replacement are limited to a single purchase of a type of DME (including repair/replacement) every [year] [[two-five] years].]</p> <p>[Benefits are [further] limited to a single Mobility Device during the entire</p>	[[50 - 100]%]	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 500] per purchase is satisfied]</p>

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>period of time a Covered Person is enrolled under the Policy. Benefits for repair of the Mobility Device are limited to once every three years. We may, upon review, replace a defective Mobility Device rather than repair it. Benefits are not available for repair or replacement of a Mobility Device resulting from abuse, neglect or normal wear.]</p> <p>[Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Policy. Benefits for repair/replacement are limited to once every three years. Speech aid and tracheo-esophageal voice devices are [not] included in the annual limits stated above.]</p>			
[8.] Emergency Health Services - Outpatient			
	[[50 - 100] %]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 700] per visit is satisfied]
<i>Include as standard for groups of 2 to 15 and 15+.</i>			
[9.] Hearing Aids			
[Prior Authorization Requirement] [You must obtain prior authorization before obtaining a hearing aid [that exceeds \$[1,000 - 5,000] in retail purchase cost]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95] % of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]			
Limited to \$[2,800 - 5,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[three-five] years]. <i>To be removed for HSA plans.</i> [No Copayment, Coinsurance or Deductible will be applicable to	[[50 - 100] %]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[50 - 1,000] per device is satisfied]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Network or non-Network Hearing Aid Coverage.]			
[10.] Home Health Care			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[You must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
<p>[Limited to [40 - 200] visits per year. One visit equals up to four hours of skilled care services.]</p> <p>[Limited to [40 - 200] visits per year to a maximum of \$[500 - 5,000] in Eligible Expenses per year.]</p> <p>[This visit limit does not include any service which is billed only for the administration of intravenous infusion.]</p>	[[50 - 100]%	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per visit is satisfied]</p>
[11.] Hospice Care			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[You must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p align="center">[In addition, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.]</p>			
	[[50 - 100]%	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per day is satisfied]</p>
[12.] Hospital - Inpatient Stay			
<p align="center">Prior Authorization Requirement</p> <p>For a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient Stay] is satisfied]
[13]. [Infertility Services]			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
[Limited to \$[2,000 - 30,000] per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. [This limit includes Benefits for infertility medications provided under the <i>Outpatient Prescription Drug Rider</i> .] This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under <i>Physician's Office Services - Sickness and Injury</i> below.]	[[50 - 100]%	[Yes] [No]	[Yes] [No]
[14.] Lab, X-Ray and Diagnostics - Outpatient			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[For sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
Lab Testing - Outpatient:	[[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per service is satisfied]
X-Ray and Other Diagnostic Testing - Outpatient:	[[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	center] [[50 - 100]% at an outpatient Hospital-based diagnostic center]		Deductible of \$[5 - 100] per service is satisfied]
[15.] Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
[Prior Authorization Requirement] [You must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[[50 - 100]%] [[50 - 100]% at a free-standing diagnostic center] [[50 - 100]% at an outpatient Hospital-based diagnostic center]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[25 - 500] per service is satisfied]
<i>Include for groups that purchase Mental Health benefits.</i> <i>[Include as standard for groups of 2 to 15]</i> ¹ <i>Include if group purchases SA benefits.</i> [16.] Mental Health Services			
[Prior Authorization Requirement] [For a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[Limits will not apply to groups of 51+.] [Inpatient Mental Health Services are	[Inpatient]		

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Neurobiological Disorders - Autism Spectrum Disorder Services</i> described in this section, <i>Mental Health Services</i> described above and <i>Substance Use Disorder Services</i> described further below are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] 	<p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>
<p>[18.] [Obesity Surgery]</p>			
<p align="center">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization [six months prior to surgery] [or] [as soon as the possibility of obesity surgery arises]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p align="center">[In addition, you must contact us 24 hours before admission for an Inpatient Stay.]</p> <p align="center">[It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.]</p>			
<p>[Benefits are limited to \$[40,000 - 250,000] during the entire period of time a Covered Person is enrolled for coverage under the Policy.]</p>	<p>[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>		
<p>[19.] [Ostomy Supplies]</p>			
<p>[Limited to \$[500 - 25,000] per year.]</p>	<p>[[50 - 100]%]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 50] per item is satisfied]</p>
<p>[20.] Pharmaceutical Products - Outpatient</p>			
<p align="center">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization five business days before scheduled intravenous infusions are</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p> <p>[You must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses. You may determine whether a particular Pharmaceutical Product requires prior authorization through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>			
<p>[The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Pharmaceutical Product, unless adjusted based on the manufacturer's packaging size, or based on supply limits. <p>When a Pharmaceutical Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.]</p>	<p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[0 - 75] per Tier 1 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[15 - 250] per Tier 2 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[20 - 450] per Tier 3 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[70 - 650] per Tier 4 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[100 - 750] per Tier 5 Pharmaceutical Product]</p> <p>[100% after you pay a Copayment of \$[150 - 850] per Tier 6 Pharmaceutical Product]</p>	<p>[Yes] [No]</p>	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per Pharmaceutical Product is satisfied]</p> <p>[Yes, except when provided during a Physician office visit]</p>

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[[50 - 100]% - Tier 1] [[50 - 100]% - Tier 2] [[50 - 100]% - Tier 3] [[50 - 100]% - Tier 4] [[50 - 100]% - Tier 5] [[50 - 100]% - Tier 6]		
[21.] Physician Fees for Surgical and Medical Services			
	[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[50 - 250] per service is satisfied]
[22.] Physician's Office Services - Sickness and Injury			
[Prior Authorization Requirement] [You must obtain prior authorization as soon as is reasonably possible before [Genetic Testing - BRCA] [Genetic Testing, including BRCA Genetic Testing] is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[[50 - 100]%] [100% after you pay a Copayment of \$[5 - 100] per visit] [100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit] [100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit; [50 - 100]% for a Specialist Physician office visit] [100% for a Primary	[Yes] [No] [Yes, when Benefits are subject to Coinsurance]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied] [Yes, when Benefits are subject to Coinsurance]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Physician office visit; [50 - 100]% for a Specialist Physician office visit]</p> <p>[100% for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per visit for a Primary Physician office visit or \$[5 - 100] per visit for a Specialist Physician office visit for the first [#] visits in a year; [50 - 90]% for any subsequent visits in that year]</p> <p>[100% for allergy injections when no other service is provided during the office visit]</p>		
<p><i>¹Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude. ²If Maternity Services are excluded, Complications of Pregnancy must always be included.]</i></p> <p>[23.] Pregnancy - [¹Maternity Services] [²Complications of Pregnancy only]</p>			
<p><i>[Include when benefits are provided for maternity services.]</i></p> <p align="center">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p> <p><i>[Include when benefits are provided for complications of pregnancy only.]</i></p> <p>[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization five business days before admission for scheduled admissions or within one business day or the same day, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p> <p>It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.</p>			
<p><i>[Include when benefits are provided for maternity services. Bracketed text within is plan design variable.]</i></p> <p>[Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> [except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay]. [For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.]]</p> <p><i>[Include when benefits are provided for complications of pregnancy only.]</i></p> <p>[Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>			
<p>[24.] Preventive Care Services</p>			
<p>Physician office services</p> <ul style="list-style-type: none"> Well baby and well child care includes, but is limited to, 20 visits at approximately the following age intervals: birth, two weeks, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, three years, four years, five years, six years, eight years, 10 years, 12 years, 14 years, 16 years, and 18 years. <p>No Copayment, Coinsurance or deductible will be applicable to Network or non-Network children's</p>	<p>100%</p>	<p>No</p>	<p>No</p>

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
immunizations.	100%	No	No
<p><i>[Prosthetics are a mandated benefit in Arkansas.]</i></p> <p>[25.] Prosthetic Devices and Services</p>			
<p align="center">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization before obtaining prosthetic devices [that exceed \$[1,000 - 5,000] in cost per device]. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
Benefits for replacement are limited to a single purchase of each type of prosthetic device every three years	[[50 - 100]%	[Yes] [No]	[Yes] [No]
[26.] Reconstructive Procedures			
<p align="center">Prior Authorization Requirement</p> <p>You must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).]</p>			
	<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>[Include when group does not purchase benefits for prosthetic devices. Bracketed text within is plan design variable.]</i></p> <p>[For breast prosthesis, mastectomy bras and lymphedema stockings for the arms, the Benefit is [50 - 100]% of Eligible Expenses [and Benefits [are] [are not] subject to payment of the Annual Deductible]. [Coinsurance [applies] [does not apply] to the Out-of-Pocket Maximum.]]</p>		
[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]			
<p align="center">[Prior Authorization Requirement]</p> <p>[You must obtain prior authorization five business days before receiving [physical therapy] [,] [and] [occupational therapy] [,] [and] [Manipulative Treatment] [,] [and] [speech therapy] [,] [and] [pulmonary rehabilitation therapy] [,] [and] [cardiac rehabilitation therapy] [,] [and] [post-cochlear implant aural therapy] [,] [and] [cognitive rehabilitation therapy] [and] [vision therapy] or as soon as is reasonably</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
<p>[Limited per year as follows:</p> <ul style="list-style-type: none"> • [[10 -100] visits of physical therapy.] • [[10 -100] visits of occupational therapy.] • [[10 -100] Manipulative Treatments.] • [[10 -100] visits of speech therapy.] • [[10 -100] visits of pulmonary rehabilitation therapy.] • [[10 -100] visits of cardiac rehabilitation therapy.] • [[10 -100] visits of post-cochlear implant aural therapy.] • [[10 - 100] visits of cognitive rehabilitation therapy.] • [[10 -100] visits of vision therapy.]] <p>[Any combination of physical therapy, occupational therapy, [Manipulative Treatment,] speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy[,] [and] cognitive rehabilitation therapy [and vision therapy] is limited to [10 - 160] visits per year.]</p>	[[50 - 100]%]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]
[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic			
[Prior Authorization Requirement] [You must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
	[[50 - 100]% [[50 - 100]% at a free-standing center]	[Yes] [No]	[Yes] [No]

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[[50 - 100]% at an outpatient Hospital-based center]		
[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, [Benefits will be reduced to 50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].</p> <p>[In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]</p>			
<p>[Limited to [40 - 180] days per year.]</p> <p>[Limited to:</p> <ul style="list-style-type: none"> • [30 - 180] days per year in a Skilled Nursing Facility. • [30 - 180] days per year in an Inpatient Rehabilitation Facility.] 	[[50 - 100]%]	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[50 - 2,000] per [day] [Inpatient Stay] is satisfied]</p>
<p>[Include as standard for groups of 2 to 15]</p> <p>[30.] Substance Use Disorder Services</p>			
<p style="text-align: center;">[Prior Authorization Requirement]</p> <p>[For a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
<p>[Limits will not apply to groups of 51+.]</p> <p>[Inpatient Substance Use Disorder Services are limited to [10 - 100] days per year.]</p> <p>[Outpatient Substance Use Disorder Services are limited to [10 - 100] visits</p>	<p>[Inpatient]</p> <p>[[50 - 100]%]</p>	[Yes] [No]	<p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[100 - 2,000] per [day] [Inpatient</p>

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>per year.]</p> <p>[Benefits for any combination of <i>Substance Use Disorder Services</i> described in this section and <i>Mental Health Services</i> described above are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] <p>[Benefits for any combination of <i>Substance Use Disorder Services</i> described in this section and <i>Mental Health Services</i> and <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i> described above are limited as follows:</p> <ul style="list-style-type: none"> [10 - 100] days per year for inpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>. [10 - 100] visits per year for outpatient <i>Neurobiological Disorders - Autism Spectrum Disorder Services</i>, <i>Mental Health Services</i> and <i>Substance Use Disorder Services</i>.] 	<p>[Outpatient]</p> <p>[[50 - 100]%]</p> <p>[100% after you pay a Copayment of \$[5 - 100] per visit]</p> <p>[100% after you pay a Copayment of \$[5 - 75] per individual visit; \$[5 - 75] per group visit.]</p> <p>[100% for visits for medication management]</p>	<p>[Yes] [No]</p>	<p>Stay] is satisfied]</p> <p>[Yes] [No]</p> <p>[Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]</p>
<p>[31.] Surgery - Outpatient</p>	<p>[Prior Authorization Requirement]</p> <p>[For [all outpatient surgeries] [[blepharoplasty] [,] [and] [cardiac catheterization] [,] [and] [cochlear implants] [,] [and] [uvulopalatopharyngoplasty] [,] [and] [pacemaker insertion] [,] [and] [pain management procedures] [,] [and] [vein procedures] [,] [and] [spine surgery] [,] [and] [total joint replacements] [,] [and] [implantable cardioverter defibrillators] [,] [and] [diagnostic catheterization and electrophysiology implant] [and] [sleep apnea surgery]] you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>		
<p>⁽¹⁾ Does not apply if prior authorization is required for all pain management.]</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	[[50 - 100]%] [[50 - 100]% at an ambulatory surgical center] [[50 - 100]% at an outpatient Hospital-based surgical center]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[10 - 1,000] per date of service is satisfied]
[32.] [Temporomandibular Joint Services]			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[You must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p> <p align="center">[In addition, you must contact us 24 hours before admission for scheduled inpatient admissions.]</p>			
[Limited to \$[1,000 - 20,000] per year.]	[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .]		
[33.] Therapeutic Treatments - Outpatient			
<p align="center">[Prior Authorization Requirement]</p> <p align="center">[²You must obtain prior authorization [for all outpatient therapeutic services] [for the following outpatient therapeutic services] five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. [Services that require prior authorization: [dialysis] [,] [and] [chemotherapy] [,] [and] [IV infusion] [,] [and] [radiation oncology] [,] [and] [intensity modulated radiation therapy] [,] [and] [hyperbaric oxygen therapy] [and] [MR-guided focused ultrasound].] If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]</p>			
	[[50 - 100]%] [[50 - 100]% at a free-standing center] [[50 - 100]% at an outpatient Hospital-based center]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[25 - 100] per treatment is satisfied]
[34.] Transplantation Services			
<p align="center">Prior Authorization Requirement</p> <p align="center">You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
[In addition, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).]			
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .			
[35.] Urgent Care Center Services			
[Limited to [2 - 10] visits per year.] •	[[50 - 100]%	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 150] per visit is satisfied]
[36.] [Vision Examinations]			
[Limited to [1 exam] [[2-3] exams] per year.] [Limited to [1 exam] [[2-3] exams] every [2 - 3] years.]	[[50 - 100]% [100% after you pay a Copayment of \$[5 - 100] per visit]	[Yes] [No]	[Yes] [No] [Yes, after the Per Occurrence Deductible of \$[5 - 100] per visit is satisfied]
[37.] [Wigs]			
[Limited to \$[100 - 1,000] per year.] [Limited to \$[100 - 5,000] every [24 - 36] months.]	[[50 - 100]%	[Yes] [No]	[Yes] [No]
Additional Benefits Required By Arkansas Law			
[38.] Dental Services - Anesthesia and Hospitalization			
Pre-service Notification Requirement Any applicable notification requirements will be the same as those stated under each Covered Health Service Category in this <i>Schedule of Benefits</i> .			
[Benefits will be the same as those stated under each Covered Health Service Category in this <i>Schedule of Benefits</i> .]			
[39.] In Vitro Fertilization Services			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
¹ Include applicable reduction in Benefits or no Benefits.			
<p style="text-align: center;">Pre-service Notification Requirement</p> <p>You must notify us as soon as the possibility of the need for in vitro fertilization arises. If you fail to notify us as required, [¹Benefits will be reduced to [50 - 95]% of Eligible Expenses] [¹you will be responsible for paying all charges and no Benefits will be paid].</p>			
Limited to a lifetime maximum of \$15,000.	[Benefits will be the same as those stated under each Covered Health Service Category in this <i>Schedule of Benefits</i> .]		
[40.] Medical Foods			
<p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, [Benefits will be reduced to [50 - 95]% of Eligible Expenses] [you will be responsible for paying all charges and no Benefits will be paid].]</p>			
	[50 - 100%]	[Yes] [No]	[Yes] [No]
<i>Mandated offer in Arkansas.</i>			
[[41.] Musculoskeletal Disorders of the Face, Neck or Head]			
<p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[Depending upon where the Covered Health Service is provided, any applicable notification or authorization requirements will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.]</p>			
	[Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .]		
[[42.] Orthotic Devices and Services			
<p><i>Include if notification is required.</i></p> <p>¹Include when notification applies only to orthotics that exceed a minimum dollar amount and insert applicable dollar amount.</p> <p>²Include applicable reduction in Benefits or no Benefits.</p> <p style="text-align: center;">[Pre-service Notification Requirement]</p> <p>[For Non-Network Benefits you must notify us before obtaining orthotic devices [¹that exceed \$[1,000 - 5,000] in cost per device]. If you fail to notify us as required, [²Benefits will be reduced to [50 - 95]% of Eligible Expenses] [²you will be responsible for paying all charges and no Benefits will be paid].]</p>			

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Benefits for replacements are limited to a single purchase of each type of orthotic device every three years.	[50 - 100%]	[Yes] [No]	[Yes] [No]

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Covered Health Services from non-Network providers, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

[Include if plan includes ability to determine alternate levels of benefits.]

[If one or more alternative health services that meets the definition of a Covered Health Service in the Certificate under Section 9: Defined Terms are clinically appropriate and not more costly than an alternative health service that is at least as likely to produce equivalent therapeutic or diagnostic results as to their prevention, diagnosis or treatment of a Sickness, Injury, [Mental Illness,] [mental illness,] substance use disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on Generally Accepted Standards of Medical Practice, which for some Covered Health Services may be addressed in our clinical policies.]

Eligible Expenses are based on either of the following:

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

[PHCS payment option.]

- *[Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.]*
- *If rates have not been negotiated, then one of the following amounts:*
 - ◆ *For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.*

[¹Include when benefits are provided for either Mental Health Services or Substance Use Disorder Services.]

If no fee information is available for a Covered Health Service, the Eligible Expense is based on [50 - 100]% of the provider's billed charge¹, except that certain Eligible Expenses for [Mental Health Services] [and] [Substance Use Disorder Services] are based on 80% of the billed charge[.]

- ◆ *[¹For [¹Mental Health Services] [¹and] [¹Substance Use Disorder Services] the Eligible Expense will be reduced by [5 - 30]% for Covered Health Services provided by a*

psychologist and by [5 - 40]% for Covered Health Services provided by a masters level counselor.]

- ◆ When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on [110 - 200]% 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.

When a rate is not published by *CMS* for the service we use 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.]

[MNRP payment option.]

- [Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.
- If rates have not been negotiated, then one of the following amounts:
 - ◆ Eligible Expenses are determined based on [110 - 200]% 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.
 - ◆ When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
 - ▶ For services other than Pharmaceutical Products, we use 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, Inc.* If the *Ingenix, Inc.* relative value scale becomes no longer available, a comparable scale will be used. We and *Ingenix, Inc.* are related companies through common ownership by *UnitedHealth Group*.
 - ▶ For Pharmaceutical Products, we use 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.

[¹Include when benefits are provided for either Mental Health Services or Substance Use Disorder Services.]

- ◆ 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 Eligible Expense is based on 50% of the provider's billed charge^[1], except that certain Eligible Expenses for [Mental Health Services] [and] [Substance Use Disorder Services] are based on 80% of the billed charge].
- ◆ [¹For [Mental Health Services] [and] [Substance Use Disorder Services] the Eligible Expense will be reduced by [5 - 30]% for Covered Health Services provided by a psychologist and by [5 - 40]% for Covered Health Services provided by a masters level counselor.]

We update the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.]

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [\[www.myuhc.com\]](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card to request a copy.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses at our discretion.

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

[Applies to plan designs that include closed-panel benefits. (Closed panel means that we pay only for drugs that are prescribed by a network provider.)]

[Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

Contraceptives are mandated in AR, except for religious group employers. ¹Remove for religious employers who choose to exclude contraceptive coverage.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service¹ or is prescribed to prevent conception].

If a Brand-name Drug Becomes Available as a Generic

[Applies when plan design includes open benefit design.]

¹Ancillary charge references here and throughout the schedule apply when plan design includes the mandatory or restrictive program.]

[If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change [¹and an Ancillary Charge may apply]. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.]

[Applies when plan design includes closed benefit design.]

¹Applies when plan design includes the mandatory or restrictive program.]

[If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change [¹and an Ancillary Charge may apply,] or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.]

[Applies when plan design includes closed-panel benefits.]

[Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per

Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

[Variable references here and throughout are used to support either notification or prior authorization requirements.]

[Notification] [Prior Authorization] Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to [\[notify\]](#) [\[obtain prior authorization from\]](#) us or our designee. The reason for [\[notifying\]](#) [\[obtaining prior authorization from\]](#) us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to [\[notify\]](#) [\[obtain prior authorization from\]](#) us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy [Notification] [Prior Authorization]

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for [\[notifying\]](#) [\[obtaining prior authorization from\]](#) us.

Non-Network Pharmacy [Notification] [Prior Authorization]

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for [\[notifying\]](#) [\[obtaining prior authorization from\]](#) us as required.

If [\[we are not notified\]](#) [\[you do not obtain prior authorization from us\]](#) before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring [\[notification\]](#) [\[prior authorization\]](#) are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires [\[notification\]](#) [\[prior authorization\]](#) through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

If [\[we are not notified\]](#) [\[you do not obtain prior authorization from us\]](#) before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

[Therapeutic class charge and therapeutically equivalent charge (here and throughout) is variable by plan design.]

When you submit a claim on this basis, you may pay more because you did not [\[notify\]](#) [\[obtain prior authorization from\]](#) us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance [\[, Ancillary Charge\]](#) [\[, Therapeutic Class Charge\]](#) [\[, Therapeutically Equivalent Charge\]](#) and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require [notification] [prior authorization] for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable [notification] [prior authorization], participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

[Step Therapy]

[Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products for which Benefits are described in your *Certificate* are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

What You Must Pay

[The following bracketed provisions are variable based upon plan design.]

[You are responsible for paying the [Annual Drug Deductible] [and] [Specialty Prescription Drug Product Annual Deductible].]

[Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.]

[Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.]

[Benefits for [insulin] [or] [diabetic supplies] are not subject to payment of the Annual Drug Deductible.]

[You are responsible for paying the Annual Deductible stated in the *Schedule of Benefits* which is attached to your *Certificate* before Benefits for Prescription Drug Products under this Rider are available to you.]

[Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Deductible.]

[Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.]

[Benefits for [insulin] [or] [diabetic supplies] are not subject to payment of the Annual Deductible.]

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table [, in addition to any Ancillary Charge] [, in addition to any] [or] Therapeutic Class Charge] [, in addition to any] [or] Therapeutically Equivalent Charge]. [You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.]

[¹Applies when the plan design includes the mandatory generic program.]

[An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your [¹or the provider's] request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the [lower tiered drug] [higher tier drug]. [An Ancillary Charge does not apply to any [Annual Drug Deductible] [,] [Annual Deductible] [,] [Specialty Prescription Drug Product Annual Deductible] [,] [or] [Out-of-Pocket Drug Maximum] [,] [or] [Out-of-Pocket Maximum] [or] [Specialty Prescription Drug Product Out-of-Pocket Maximum].]]

[A Therapeutic Class Charge may apply when the Prescription Drug Charge or the Predominant Reimbursement Rate of the Prescription Drug Product exceeds the Maximum Allowable Amount. You are responsible for the Therapeutic Class Charge and any applicable Copayment and/or Coinsurance.]

[A Therapeutically Equivalent Charge may apply when the Prescription Drug Charge or the Predominant Reimbursement Rate of the Prescription Drug Product exceeds the Maximum Allowable Amount. You are responsible for the Therapeutically Equivalent Charge and any applicable Copayment and/or Coinsurance.]

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in your *Certificate*:

- [Copayments for Prescription Drug Products [, including Specialty Prescription Drug Products].]
- [Coinsurance for Prescription Drug Products [, including Specialty Prescription Drug Products].]
- [Ancillary Charges.]
- [Therapeutic Class Charges.]
- [Therapeutically Equivalent Charges.]
- [The Annual Drug Deductible.]
- [The Specialty Prescription Drug Product Annual Deductible.]
- [Any amount you pay for Prescription Drug Products for Infertility that exceeds the Infertility Annual Maximum Benefit.]
- [Any amount you pay for Prescription Drug Products for Infertility that exceeds the Infertility Maximum Policy Benefit.]
- The difference between the Predominant Reimbursement Rate and a non-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

[The following provisions are plan design variable.]

[The Annual Drug Deductibles are calculated on a [calendar] [Policy] year basis.]

[The Specialty Prescription Drug Product Annual Deductibles are calculated on a [calendar] [Policy] year basis.]

[The Out-of-Pocket Drug Maximums are calculated on a [calendar] [Policy] year basis.]

[The Specialty Prescription Drug Product Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.]

[The Infertility Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

Payment Term And Description	Amounts
[Annual Drug Deductible]	
<p><i>[Annual drug deductible is plan design variable.]</i></p> <p><i>[Option 1: Applies when the annual drug deductible is determined based on network or non-network status.]</i></p> <p>[The amount you pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and Tier 6]] Prescription Drug Products [at a Network Pharmacy] [at a non-Network Pharmacy] [at a Network or non-Network Pharmacy] in a year before we begin paying for Prescription Drug Products.]</p> <p><i>[Option 2: Applies when the annual drug deductible is determined based on tier status.]</i></p> <p>[The amount you pay for covered [[Tier 1] [,] [Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and] [Tier 6]] Prescription Drug Products [at a Network Pharmacy] [at a non-Network Pharmacy] [at a Network or non-Network Pharmacy] in a year before we begin paying for Prescription Drug Products.]</p> <p>[Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.]</p> <p>[Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.]</p> <p>[Benefits for [insulin] [or] [diabetic supplies] are not subject to payment of</p>	<p><i>[The variables below correspond with Option 1.]</i></p> <p>[Network]</p> <p>[No Annual Drug Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p>[Non-Network]</p> <p>[No Annual Drug Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p>[Network and Non-Network]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p><i>[The variables below correspond with Option 2.]</i></p> <p>[Tier 1]</p> <p>[No Annual Drug Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p>[Tier 2]</p> <p>[No Annual Drug Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p>

Payment Term And Description	Amounts
<p>the Annual Drug Deductible.]</p> <p><i>[¹Applies when only the individual portion is subject to the annual drug deductible.]</i></p> <p>[Any amount you pay that is applied to the Annual Drug Deductible in the last quarter of the previous [calendar] [Policy] year will be carried over and applied to the current Annual Drug Deductible. [¹This carry-over feature applies only to the individual Annual Drug Deductible.]]</p> <p>[When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual drug deductible provision of the prior policy will apply to the Annual Drug Deductible provision under the Policy.]</p> <p><i>[Applies when the roll-over provision applies to a group changing from a calendar year to policy year plan.]</i></p> <p><i>[¹Applies when only the individual portion is subject to the annual drug deductible.]</i></p> <p>[When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for Prescription Drug Product expenses in the last three months of the previous calendar year that is applied to the previous Annual Drug Deductible, will be rolled over and applied to the current Policy year Annual Drug Deductible. This roll-over feature applies only to the first Policy year. [¹This roll-over feature applies only to the individual Annual Drug Deductible.]]</p> <p>[Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>	<p>[Tier 3]</p> <p>[No Annual Drug Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p>[Tier 4]</p> <p>[No Annual Drug Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p>[Tier 5]</p> <p>[No Annual Drug Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p>[Tier 6]</p> <p>[No Annual Drug Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p>[Tiers [1] [,] [and] [2] [,] [and] [3] [,] [and] [4] [,] [and] [5] [and] [6]]</p> <p>[No Annual Drug Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p>
<p>[Specialty Prescription Drug Product</p>	

Payment Term And Description	Amounts
Annual Deductible]	
<p><i>[Specialty annual deductible is plan design variable.]</i></p> <p><i>[Option 1: Applies when the specialty annual deductible is determined based on either specialty prescription drug product, per specialty drug product, per therapeutic class and/or growth hormone therapy.]</i></p> <p>[The amount you pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [,] and] [Tier 6]] Specialty Prescription Drug Products [at a Network Pharmacy] [at a non-Network Pharmacy] [at a Network or non-Network Pharmacy] [or] [a Designated Pharmacy] in a year before we begin paying for Specialty Prescription Drug Products.]</p> <p><i>[Option 2: Applies when the specialty annual deductible is determined based on tier status.]</i></p> <p>[The amount you pay for covered [[Tier 1] [,] [Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [,] and] [Tier 6]] Specialty Prescription Drug Products [at a Network Pharmacy] [at a non-Network Pharmacy] [at a Network or non-Network Pharmacy] [or] [a Designated Pharmacy] in a year before we begin paying for Specialty Prescription Drug Products.]</p> <p><i>[¹ Applies when only the individual portion of the specialty prescription drug product annual deductible is subject to the carry-over feature.]</i></p> <p>[Any amount you pay that is applied to the Specialty Prescription Drug Product Annual Deductible in the last quarter of the previous [calendar] [Policy] year will be carried over and applied to the current year's Specialty Prescription Drug Product Annual Deductible. [¹This carry-over feature applies only to the individual Specialty Prescription Drug Product Annual Deductible.]]</p> <p>[When a Covered Person was previously covered under a group policy that was replaced by the group Policy,</p>	<p><i>[The variable provisions below correspond with Option 1.]</i></p> <p>[Specialty Prescription Drug Product]</p> <p><i>[Include when individual specialty prescription drug product deductible applies.]</i></p> <p>[\$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products.] [This does not include any deductible stated below.]</p> <p>[\$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products, not to exceed \$[200 - 3,000] for all Covered Persons in a family.] [This does not include any deductible stated below.]</p> <p>[Specialty - Per Specialty Prescription Drug Product]</p> <p>[\$[100 - 1,000] per Specialty Prescription Drug Product per Covered Person.] [This does not include any deductible stated below.]</p> <p>[\$[100 - 1,000] per Specialty Prescription Drug Product per Covered Person, not to exceed \$[200 - 3,000] per Specialty Prescription Drug Product for all Covered Persons in a family.] [This does not include any deductible stated below.]</p> <p>[Specialty - Growth Hormone Therapy]</p> <p>[\$[100 - 1,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person.]</p> <p>[\$[100 - 1,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person, not to exceed \$[200 - 3,000] for growth hormone therapy for all Covered Persons in a family.]</p> <p>[Specialty - Per Therapeutic Class]</p> <p>[No Specialty Prescription Drug Product Annual Deductible for Therapeutic Class A.]</p> <p>[\$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class A.]</p> <p>[\$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class A, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p>[No Specialty Prescription Drug Product Annual Deductible for Therapeutic Class B.]</p> <p>[\$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class B.]</p> <p>[\$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class B, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p>[No Specialty Prescription Drug Product Annual Deductible for Therapeutic Class C.]</p> <p>[\$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class C.]</p>

Payment Term And Description	Amounts
<p>any amount already applied to that specialty prescription drug product annual deductible provision of the prior policy will apply to the Specialty Prescription Drug Product Annual Deductible provision under the Policy.]</p> <p><i>[¹Applies when only the individual portion of the specialty prescription drug product annual deductible is subject to the roll-over provision for groups changing from a calendar year to policy year plan.]</i></p> <p>[When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for Specialty Prescription Drug Product expenses in the last three months of the previous calendar year that is applied to the previous Specialty Prescription Drug Product Annual Deductible, will be rolled over and applied to the current Policy year Specialty Prescription Drug Product Annual Deductible. This roll-over feature applies only to the first Policy year. [¹This roll-over feature applies only to the individual Specialty Prescription Drug Product Annual Deductible.]]</p> <p>[The Specialty Prescription Drug Product Annual Deductible is included in the overall Annual Drug Deductible stated above.]</p> <p>[Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Specialty Prescription Drug Product Annual Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>	<p>[\$[100 - 1,000] per Covered Person for Specialty Prescription Drug Products in Therapeutic Class C, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p><i>[The variable provisions below correspond with Option 2.]</i></p> <p>[Tier 1]</p> <p>[No Specialty Prescription Drug Product Annual Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p>[Tier 2]</p> <p>[No Specialty Prescription Drug Product Annual Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p>[Tier 3]</p> <p>[No Specialty Prescription Drug Product Annual Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p>[Tier 4]</p> <p>[No Specialty Prescription Drug Product Annual Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p>[Tier 5]</p> <p>[No Specialty Prescription Drug Product Annual Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p>[Tier 6]</p> <p>[No Specialty Prescription Drug Product Annual Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p>[Tiers [1] [,] [and] [2] [,] [and] [3] [,] [and] [4] [,] [and] [5] [and] [6]]</p> <p>[No Specialty Prescription Drug Product Annual Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all</p>

Payment Term And Description	Amounts
	Covered Persons in a family.]
[Out-of-Pocket Drug Maximum]	
<p><i>[Out-of-pocket drug maximum is plan design variable. Include applicable provisions to support the following:]</i></p> <p>¹<i>The out-of-pocket drug maximum applies annually.]</i></p> <p>²<i>The annual out-of-pocket drug maximum includes copayments.]</i></p> <p>³<i>The annual out-of-pocket drug maximum does not include copayments.]</i></p> <p>⁴<i>The out-of-pocket drug maximum applies monthly.]</i></p> <p>⁵<i>The monthly out-of-pocket drug maximum includes copayments.]</i></p> <p>⁶<i>The monthly out-of-pocket drug maximum does not include copayments.]</i></p> <p>¹The maximum amount you are required to pay for covered Prescription Drug Products in a single year. Once you reach the Out-of-Pocket Drug Maximum, you will not be required to pay [²Copayments or] Coinsurance for covered Prescription Drug Products for the remainder of the year. [³The Out-of-Pocket Drug Maximum does not include Copayments.]]</p> <p>⁴The maximum amount you are required to pay for covered Prescription Drug Products in a single calendar month. Once you reach the Out-of-Pocket Drug Maximum, you will not be required to pay [⁵Copayments or] Coinsurance for covered Prescription Drug Products for the remainder of the calendar month. [⁶The Out-of-Pocket Drug Maximum does not include Copayments.]]</p> <p>[Copayments and Coinsurance for covered Specialty Prescription Drug Products are not limited by the Out-of-Pocket Drug Maximum.]</p> <p>[Copayments and Coinsurance for covered Prescription Drug Products for</p>	<p><i>[Insert maximum amounts according to benefit design chosen by group.]</i></p> <p>¹<i>Include if copayments and coinsurance are not subject to an out-of-pocket drug maximum.]</i></p> <p>²<i>Include if copayments and/or coinsurance are subject to an out-of-pocket drug maximum and the benefit design includes an annual drug deductible.]</i></p> <p>³<i>If an annual drug deductible applies, select the appropriate statement about whether or not the annual drug deductible applies to the out-of-pocket drug maximum.]</i></p> <p>[Network]</p> <p><i>[Include when individual out-of-pocket drug maximum applies.]</i></p> <p>[\$500 - 10,000] per Covered Person.]</p> <p><i>[Include when individual (with family maximum) out-of-pocket drug maximum applies.]</i></p> <p>[\$500 - 10,000] per Covered Person, not to exceed \$[1,000 - 30,000] for all Covered Persons in a family.]</p> <p>¹Copayments and Coinsurance for Prescription Drug Products are not limited by an Out-of-Pocket Drug Maximum.]</p> <p>²The Out-of-Pocket Drug Maximum [³includes] [³does not include] the Annual Drug Deductible.]</p> <p>[Non-Network]</p> <p><i>[Include when individual out-of-pocket drug maximum applies.]</i></p> <p>[\$500 - 10,000] per Covered Person.]</p> <p><i>[Include when individual (with family maximum) out-of-pocket drug maximum applies.]</i></p> <p>[\$500 - 10,000] per Covered Person, not to exceed \$[1,000 - 30,000] for all Covered Persons in a family.]</p> <p>¹Copayments and Coinsurance for Prescription Drug Products are not limited by an Out-of-Pocket Drug Maximum.]</p> <p>²The Out-of-Pocket Drug Maximum [³includes] [³does not include] the Annual Drug Deductible.]</p> <p>[Network and Non-Network]</p> <p><i>[Include when individual out-of-pocket drug maximum applies.]</i></p> <p>[\$500 - 10,000] per Covered Person.]</p> <p><i>[Include when individual (with family maximum) out-of-pocket drug maximum applies.]</i></p> <p>[\$500 - 10,000] per Covered Person, not to exceed \$[1,000 - 30,000] for</p>

Payment Term And Description	Amounts
Infertility are not limited by the Out-of-Pocket Drug Maximum.]	all Covered Persons in a family.] [² The Out-of-Pocket Drug Maximum [³ includes] [³ does not include] the Annual Drug Deductible.]
[Specialty Prescription Drug Product Out-of-Pocket Maximum]	
<p><i>[Specialty out-of-pocket maximum is plan design variable. Include applicable provisions to support the following:]</i></p> <p>¹<i>The specialty out-of-pocket drug maximum applies annually.]</i></p> <p>²<i>The specialty annual out-of-pocket drug maximum includes copayments.]</i></p> <p>³<i>The specialty annual out-of-pocket drug maximum does not include copayments.]</i></p> <p>⁴<i>The specialty out-of-pocket drug maximum applies monthly.]</i></p> <p>⁵<i>The specialty monthly out-of-pocket drug maximum includes copayments.]</i></p> <p>⁶<i>The specialty monthly out-of-pocket drug maximum does not include copayments.]</i></p> <p>[¹The maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single year. Once you reach the Specialty Prescription Drug Product Out-of-Pocket Maximum, you will not be required to pay [²Copayments or] Coinsurance for covered Specialty Prescription Drug Products for the remainder of the year. [³The Specialty Prescription Drug Product Out-of-Pocket Maximum does not include Copayments.]]</p> <p>[⁴The maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single calendar month. Once you reach the Specialty Prescription Drug Product Out-of-Pocket Maximum, you will not be required to pay [⁵Copayments or] Coinsurance for covered Specialty Prescription Drug Products for the remainder of the calendar month. [⁶The Specialty Prescription Drug Product Out-of-Pocket Maximum does not</p>	<p>[Specialty Prescription Drug Product]</p> <p><i>[Include when individual specialty out-of-pocket maximum applies.]</i></p> <p>[\$500 - 10,000] for Specialty Prescription Drug Products per Covered Person.] [This does not include any maximum stated below.]</p> <p><i>[Include when individual (with family maximum) specialty out-of-pocket maximum applies.]</i></p> <p>[\$500 - 10,000] for Specialty Prescription Drug Products per Covered Person, not to exceed \$[1,000 - 30,000] for all Covered Persons in a family.] [This does not include any maximum stated below.]</p> <p>[This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.]</p> <p>[Copayments and Coinsurance for covered Specialty Prescription Drug Products are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.]</p> <p>[Specialty - Per Specialty Prescription Drug Product]</p> <p>[\$500 - 10,000] per Specialty Prescription Drug Product per Covered Person.] [This does not include any maximum stated below.]</p> <p>[\$500 - 10,000] per Specialty Prescription Drug Product per Covered Person, not to exceed \$[1,000 - 30,000] per Specialty Prescription Drug Product for all Covered Persons in a family.] [This does not include any maximum stated below.]</p> <p>[This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.]</p> <p>[Specialty - Growth Hormone Therapy]</p> <p>[\$500 - 10,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person.]</p> <p>[\$500 - 10,000] for Specialty Prescription Drug Products for growth hormone therapy per Covered Person, not to exceed \$[1,000 - 30,000] for growth hormone therapy for all Covered Persons in a family.]</p> <p>[This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.]</p> <p>[Specialty - per Therapeutic Class]</p> <p>[\$500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class A per Covered Person.]</p>

Payment Term And Description	Amounts
<p>include Copayments.]]</p> <p>[Copayments and Coinsurance for covered Specialty Prescription Drug Products for Infertility are not limited by the Specialty Prescription Drug Product Out-of-Pocket Maximum.]</p>	<p>[\$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class A per Covered Person, not to exceed \$[1,000 - 30,000] for all Covered Persons in a family.]</p> <p>[Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class A are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.]</p> <p>[This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.]</p> <p>[\$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class B per Covered Person.]</p> <p>[\$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class B per Covered Person, not to exceed \$[1,000 - 30,000] for all Covered Persons in a family.]</p> <p>[Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class B are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.]</p> <p>[This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.]</p> <p>[\$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class C per Covered Person.]</p> <p>[\$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class C per Covered Person, not to exceed \$[1,000 - 30,000] for all Covered Persons in a family.]</p> <p>[Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class C are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.]</p> <p>[This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Specialty Prescription Drug Product Annual Deductible.]</p>
<p>[Infertility Annual Maximum Benefit]</p>	
<p><i>[Applicability of infertility annual maximum drug benefit is plan design variable.]</i></p> <p>[The maximum amount we will pay for covered Prescription Drug Products for Infertility during a year.]</p>	<p>[\$[250 - 10,000] per Covered Person.]</p>
<p>[Infertility Maximum Policy Benefit]</p>	
<p><i>[Applicability of infertility maximum policy benefit is plan design variable.]</i></p> <p>[The maximum amount we will pay for covered Prescription Drug Products for Infertility during the entire period of time</p>	<p>[\$[250 - 10,000] per Covered Person.]</p>

Payment Term And Description	Amounts
<p>you are enrolled for coverage under the Policy.]</p>	
<p>Copayment and Coinsurance</p>	
<p>Copayment</p> <p>Copayment for a Prescription Drug Product at a Network or non-Network Pharmacy is a specific dollar amount.</p> <p>Coinsurance</p> <p>Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge.</p> <p>Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate.</p> <p>Copayment and Coinsurance</p> <p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product.</p> <p>[Your Copayment and/or Coinsurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable [notification] [prior authorization], participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.]</p> <p>Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling</p>	<p>[¹Applies when our negotiated rate does not apply.]</p> <p>[²Applies when our negotiated rate applies.]</p> <p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the [¹lower] [²lowest] of the following:</p> <ul style="list-style-type: none"> • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • [²The Prescription Drug Charge for that Prescription Drug Product.] <p>[For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> • The applicable Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product.] <p>See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts.</p> <p>[You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.]</p>

Payment Term And Description	Amounts
<p><i>Customer Care</i> at the telephone number on your ID card.</p> <p>Prescription Drug Products Prescribed by a Specialist Physician: You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card for the most up-to-date tier status.</p> <p>[Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
<p><i>[The specialty prescription drug product benefit description is plan design variable.]</i></p> <p>[Specialty Prescription Drug Products]</p>	
<p>[The following supply limits apply.]</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive [31] [60]-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. <p>When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive [31]-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p> <p>Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy [,] [or] a non-Network Pharmacy [,] [or] [a mail order Network Pharmacy] [or] [a Designated Pharmacy].]</p>	<p><i>[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments/coinsurance for growth hormone therapy; differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of preventive medications.]</i></p> <p>[Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [,] [or] [Tier 5] [,] or Tier 6]. Please access [www.myuhc.com] through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.]</p> <p>[Network Pharmacy]</p> <p>[For a Tier 1 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-75]] per Prescription Order or Refill [,] except that we pay [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of \$[0-75]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-75]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-75]]] [,] and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-75]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[7-35]] [you will not pay more than \$[35-75]] [you will not pay less than \$[7-35] and you will not pay more than \$[35-75]] per Prescription Order or Refill.]]</p> <p>[For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[5-35]] [you will not pay more than \$[35-75]] [you will not pay less than \$[5-35] and you will not pay more than \$[35-75]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[15-250]] per Prescription Order or Refill [,] except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of \$[15-250]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[15-250]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[15-250]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[15-250]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[15-125]] [you will not pay more than \$[125-250]] [you will not pay less than \$[15-125] and you will not pay more than \$[125-250]] per Prescription Order or Refill.]</p> <p>[For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-250]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[10-125]] [you will not pay more than \$[125-250]] [you will not pay less than \$[10-125] and you will not pay more than \$[125-250]] per Prescription Order or Refill.]</p> <p>[For a Tier 3 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[20-450]] per Prescription Order or Refill [,] except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of \$[20-450]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[25-450]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[25-450]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[25-450]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[20-225]] [you will not pay more than \$[225-450]] [you will not pay less than \$[20-225] and you will not pay more than \$[225-450]] per Prescription Order or Refill.]</p> <p>[For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[15-225]] [you will not pay more than \$[225-450]] [you will not pay less than \$[15-225] and you will not pay more than \$[225-450]] per Prescription Order or Refill.]</p> <p>[For a Tier 4 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[70-650]] per Prescription Order or Refill [,] except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of \$[70-650]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[80-650]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[80-650]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[80-650]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[70-</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>360]] [you will not pay more than \$[360-650]] [you will not pay less than \$[70-360] and you will not pay more than \$[360-650]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[50-360]] [you will not pay more than \$[360-650]] [you will not pay less than \$[50-360] and you will not pay more than \$[360-650]] per Prescription Order or Refill.]]</p> <p>[For a Tier 5 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[100-750]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of \$[100-750]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[125-750]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[125-750]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[125-750]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[100-425]] [you will not pay more than \$[425-750]] [you will not pay less than \$[100-425] and you will not pay more than \$[425-750]] per Prescription Order or Refill.]]</p> <p>[For a Tier 5 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[75-425]] [you will not pay more than \$[425-750]] [you will not pay less than \$[75-425] and you will not pay more than \$[425-750]] per Prescription Order or Refill.]]</p> <p>[For a Tier 6 Specialty Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[150-850]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of \$[150-850]]] [and we pay] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[175-850]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[175-850]]] [, and] [[50-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[175-850]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[150-500]] [you will not pay more than \$[500-850]] [you will not pay less than \$[150-500] and you will not pay more than \$[500-850]] per Prescription Order or Refill.]]</p> <p>[For a Tier 6 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-850]] per Prescription Order or Refill.</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>[[However,] [you will not pay less than \$[100-500]] [you will not pay more than \$[500-850]] [you will not pay less than \$[100-500] and you will not pay more than \$[500-850]] per Prescription Order or Refill.]]</p> <p>[No Copayment]</p> <p>[Non-Network Pharmacy]</p> <p>[For a Tier 1 Specialty Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-75]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of \$[0-75]]] [and we pay] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-75]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-75]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-75]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[7-35]] [you will not pay more than \$[35-75]] [you will not pay less than \$[7-35] and you will not pay more than \$[35-75]] per Prescription Order or Refill.]]</p> <p>[For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[5-35]] [you will not pay more than \$[35-75]] [you will not pay less than \$[5-35] and you will not pay more than \$[35-75]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Specialty Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[15-250]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of \$[15-250]]] [and we pay] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[15-250]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[15-250]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[15-250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[15-125]] [you will not pay more than \$[125-250]] [you will not pay less than \$[15-125] and you will not pay more than \$[125-250]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-250]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[15-225]] [you will not pay more than \$[225-450]] [you will not pay less than \$[15-225] and you will not pay more than \$[225-450]] per Prescription Order or Refill.]]</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>[For a Tier 3 Specialty Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[20-450]] per Prescription Order or Refill [, except that we pay [³[50-100] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of \$[20-450]]] [and we pay] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[25-450]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[25-450]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[25-450]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[20-225]] [you will not pay more than \$[225-450]] [you will not pay less than \$[20-225] and you will not pay more than \$[225-450]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[15-225]] [you will not pay more than \$[225-450]] [you will not pay less than \$[15-225] and you will not pay more than \$[225-450]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Specialty Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[70-650]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of \$[70-650]]] [and we pay] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[80-650]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[80-650]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[80-650]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[70-360]] [you will not pay more than \$[360-650]] [you will not pay less than \$[70-360] and you will not pay more than \$[360-650]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[50-360]] [you will not pay more than \$[360-650]] [you will not pay less than \$[50-360] and you will not pay more than \$[360-650]] per Prescription Order or Refill.]]</p> <p>[For a Tier 5 Specialty Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[100-750]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of \$[100-750]]] [and we pay] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>Therapeutic Class [A] [after you pay a Copayment of \$[125-750]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[125-750]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[125-750]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[100-425]] [you will not pay more than \$[425-750]] [you will not pay less than \$[100-425] and you will not pay more than \$[425-750]] per Prescription Order or Refill.]]</p> <p>[For a Tier 5 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[100-425]] [you will not pay more than \$[425-750]] [you will not pay less than \$[100-425] and you will not pay more than \$[425-750]] per Prescription Order or Refill.]]</p> <p>[For a Tier 6 Specialty Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[150-850]] per Prescription Order or Refill [, except that we pay [[50-100] % of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy [after you pay a Copayment of \$[150-850]]] [and we pay] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[175-850]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[175-850]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[175-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[150-500]] [you will not pay more than \$[500-850]] [you will not pay less than \$[150-500] and you will not pay more than \$[500-850]] per Prescription Order or Refill.]]</p> <p>[For a Tier 6 Specialty Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[100-500]] [you will not pay more than \$[500-850]] [you will not pay less than \$[100-500] and you will not pay more than \$[500-850]] per Prescription Order or Refill.]]</p> <p>[No Copayment]</p> <p><i>[Applies when closed benefit plan applies.]</i></p> <p>[Specialty Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.]</p>
<p>Prescription Drugs from a Retail Network Pharmacy</p> <p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a 	<p><i>[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments]</i></p>

Description and Supply Limits	Benefit (The Amount We Pay)
<p>consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.</p> <ul style="list-style-type: none"> If the Network Pharmacy agrees to provide the same services or products for the same terms as the Mail Order Network Pharmacy, you may obtain up to a consecutive 90-day supply of a Prescription Drug Product. <p><i>Contraceptives are mandated in AR, except for religious group employers. ¹Remove for religious employers who choose to exclude contraceptive coverage.</i></p> <ul style="list-style-type: none"> ¹A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied.] <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p> <p><i>[Applies when plan design includes ¹preferred retail network pharmacy and/or ²non-preferred retail network pharmacy. ³Applies when plan design includes both preferred and non-preferred retail network pharmacy.]</i></p> <p>[We may designate certain retail Network Pharmacies to be ¹a Preferred Retail Network Pharmacy] ³and/or] ²a Non-Preferred Retail Network Pharmacy]. We may periodically change the ¹Preferred] ³and/or] ²Non-Preferred] designation of a retail Network Pharmacy. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you. You may determine whether a retail Network Pharmacy is a ¹Preferred Retail Network Pharmacy]</p>	<p><i>/coinsurance by therapeutic class; and different copayments for drugs on the list of preventive medications.]</i></p> <p>[Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [,] [or] [Tier 5] [,] or Tier 6]. Please access [www.myuhc.com] through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.]</p> <p>[For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-75]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-75]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-75]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-75]]] per Prescription Order or Refill]. [[However,] you will not pay less than \$[7-35] [you will not pay more than \$[35-75] [you will not pay less than \$[7-35] and you will not pay more than \$[35-75]] per Prescription Order or Refill.]]</p> <p>[For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-75]] per Prescription Order or Refill. [[However,] you will not pay less than \$[5-35] [you will not pay more than \$[35-75] [you will not pay less than \$[5-35] and you will not pay more than \$[35-75]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[15-250]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[15-250]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[15-250]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[15-250]]] per Prescription Order or Refill]. [[However,] you will not pay less than \$[15-125] [you will not pay more than \$[125-250] [you will not pay less than \$[15-125] and you will not pay more than \$[125-250]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-250]] per Prescription Order or Refill. [[However,] you will not pay less than \$[10-125] [you will not pay more than \$[125-250] [you will not pay less than \$[10-125] and you will not pay more than \$[125-250]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[20-450]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after</p>

Description and Supply Limits	Benefit (The Amount We Pay)
<p>[³or a] [²Non-Preferred Retail Network Pharmacy] through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p> <p><i>[Applies when plan design includes preferred retail network pharmacy and copayments and/or coinsurance are reduced for prescription drug products obtained at a preferred pharmacy.]</i></p> <p>[If you use a Preferred Retail Network Pharmacy, your Copayment will be reduced by a minimum of \$[1 - 60] per Prescription Order or Refill.]</p> <p>[If you use a Preferred Retail Network Pharmacy, your Coinsurance will be reduced by a minimum of \$[1 - 60] per Prescription Order or Refill.]</p> <p>[If you use a Preferred Retail Network Pharmacy, your Coinsurance will be reduced by a minimum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.]</p> <p><i>[Applies when plan design includes non-preferred retail network pharmacy and copayments and/or coinsurance are increased when prescription drug products are obtained at a non-preferred pharmacy.]</i></p> <p>[If you use a Non-Preferred Retail Network Pharmacy, your Copayment will be increased by a maximum of \$[1 - 60] per Prescription Order or Refill.]</p> <p>[If you use a Non-Preferred Retail Network Pharmacy, your Coinsurance will be increased by a maximum of \$[1 - 60] per Prescription Order or Refill.]</p> <p>[If you use a Non-Preferred Retail Network Pharmacy, your Coinsurance will be increased by a maximum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.]</p>	<p>you pay a Copayment of \$[20-450]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[20-450]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[20-450]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[20-225]] [you will not pay more than \$[225-450]] [you will not pay less than \$[20-225] and you will not pay more than \$[225-450]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[15-225]] [you will not pay more than \$[225-450]] [you will not pay less than \$[15-225] and you will not pay more than \$[225-450]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[70-650]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[70-650]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[70-650]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[70-650]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[70-360]] [you will not pay more than \$[360-650]] [you will not pay less than \$[70-360] and you will not pay more than \$[360-650]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[50-360]] [you will not pay more than \$[360-650]] [you will not pay less than \$[50-360] and you will not pay more than \$[360-650]] per Prescription Order or Refill.]]</p> <p>[For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[100-750]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[100-750]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[100-750]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[100-750]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[100-425]] [you will not pay more than \$[425-750]] [you will not pay less than \$[100-450] and you will not pay more than \$[425-750]] per Prescription Order or Refill.]]</p> <p>[For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-750]] per Prescription Order or Refill. [[However,] [you</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>will not pay less than \$[75-425]] [you will not pay more than \$[425-750]] [you will not pay less than \$[75-425] and you will not pay more than \$[425-750]] per Prescription Order or Refill.]]</p> <p>[For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[150-850]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[150-850]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[150-850]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[150-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[150-500]] [you will not pay more than \$[500-850]] [you will not pay less than \$[150-500] and you will not pay more than \$[500-850]] per Prescription Order or Refill.]]</p> <p>[For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[100-500]] [you will not pay more than \$[500-850]] [you will not pay less than \$[100-500] and you will not pay more than \$[500-850]] per Prescription Order or Refill.]]</p> <p>[No Copayment]</p> <p><i>[Applies when closed benefit plan applies.]</i></p> <p>[Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.]</p> <p><i>[Include when 90 day generic coverage applies.]</i></p> <p>[For a 90-day supply of a Generic for which the Usual and Customary Charge does not exceed \$[10 - 20], we pay:]</p> <p>[For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per Prescription Order or Refill.]]</p> <p>[For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per Prescription Order or Refill.]]</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>[For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-20] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>Copayment of \$[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per Prescription Order or Refill.]]</p> <p>[For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-20] [,] and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per Prescription Order or Refill.]]</p> <p>[For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per Prescription Order or Refill.]]</p> <p>[For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-20] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-20] [,] and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-20] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per Prescription Order or Refill.]]</p> <p>[For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per Prescription Order or Refill.]]</p> <p>[No Copayment]</p> <p><i>[Applies when closed benefit plan applies.]</i></p> <p>[Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.]</p>
<p>Prescription Drugs from a Retail Non-Network Pharmacy</p>	

Description and Supply Limits	Benefit (The Amount We Pay)
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. <p><i>Contraceptives are mandated in AR, except for religious group employers. ¹Remove for religious employers who choose to exclude contraceptive coverage.</i></p> <ul style="list-style-type: none"> <i>[¹A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied.]</i> <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p>	<p><i>[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of preventive medications.]</i></p> <p>[Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [,] [or] [Tier 5] [, or Tier 6]. Please access [www.myuhc.com] through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.]</p> <p>[For a Tier 1 Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-75]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-75]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-75]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-75]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[7-35]] [you will not pay more than \$[35-75]] [you will not pay less than \$[7-35] and you will not pay more than \$[35-75]] per Prescription Order or Refill.]]</p> <p>[For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[5-35]] [you will not pay more than \$[35-75]] [you will not pay less than \$[5-35] and you will not pay more than \$[35-75]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[15-250]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[15-250]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[15-250]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[15-250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[15-125]] [you will not pay more than \$[125-250]] [you will not pay less than \$[15-125] and you will not pay more than \$[125-250]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-250]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[10-125]] [you will not pay more than \$[125-250]] [you will not pay less than \$[10-125] and you will not pay more than \$[125-250]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Prescription Drug Product: [50-100]% of the Predominant</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>Reimbursement Rate [after you pay a Copayment of \$[20-450]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[25-450]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[25-450]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[25-450]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[20-225]] [you will not pay more than \$[225-450]] [you will not pay less than \$[20-225] and you will not pay more than \$[225-450]] per Prescription Order or Refill.]</p> <p>[For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[15-225]] [you will not pay more than \$[225-450]] [you will not pay less than \$[15-225] and you will not pay more than \$[225-450]] per Prescription Order or Refill.]</p> <p>[For a Tier 4 Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[70-650]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[80-650]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[80-650]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[80-650]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[70-360]] [you will not pay more than \$[360-650]] [you will not pay less than \$[70-360] and you will not pay more than \$[360-650]] per Prescription Order or Refill.]</p> <p>[For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[50-360]] [you will not pay more than \$[360-650]] [you will not pay less than \$[50-360] and you will not pay more than \$[360-650]] per Prescription Order or Refill.]</p> <p>[For a Tier 5 Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[100-750]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[125-750]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[125-750]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[125-750]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[100-425]] [you will not pay more than \$[425-750]] [you will not pay less than \$[100-425] and you will not pay more than \$[425-750]] per Prescription Order or</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>Refill.]]</p> <p>[For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[75-425]] [you will not pay more than \$[425-750]] [you will not pay less than \$[75-425] and you will not pay more than \$[425-750]] per Prescription Order or Refill.]]</p> <p>[For a Tier 6 Prescription Drug Product: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[150-850]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[175-850]]] [,] [and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[175-850]]] [, and] [[50-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[175-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[150-500]] [you will not pay more than \$[500-850]] [you will not pay less than \$[150-500] and you will not pay more than \$[500-850]] per Prescription Order or Refill.]]</p> <p>[For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[100-500]] [you will not pay more than \$[500-850]] [you will not pay less than \$[100-500] and you will not pay more than \$[500-850]] per Prescription Order or Refill.]]</p> <p>[No Copayment]</p> <p><i>[Applies when closed benefit plan applies.]</i></p> <p>[Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.]</p>
<p><i>[Applies when plan design includes a mail order benefit.]</i></p> <p>[Prescription Drug Products from a Mail Order Network Pharmacy]</p>	
<p>[The following supply limits apply:</p> <p>^[1] <i>Applies when plan design includes specialty drug program.]</i></p> <p>^[2] <i>Apply when plan design includes the list of preventive medications.]</i></p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or 	<p><i>[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of preventive medications.]</i></p> <p>[Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [,] [or] [Tier 5] [, or Tier 6]. Please access [www.myuhc.com] through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.]</p>

Description and Supply Limits	Benefit (The Amount We Pay)
<p>based on supply limits. [¹These supply limits do not apply to Specialty Prescription Drug Products², including Specialty Prescription Drug Products on the List of Preventive Medications]. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading <i>Specialty Prescription Drug Products</i>.]</p> <p><i>[Applies when coverage is initially required at a retail pharmacy prior to using mail order.]</i></p> <p>[You may be required to fill an initial Prescription Drug Product order and obtain [1 - 3] refill[s] through a retail pharmacy prior to using a mail order Network Pharmacy.]</p> <p><i>[Applies when initial mail day supply is limited.]</i></p> <p>[You may be limited to a 31-day supply for your initial fill and [1 - 3] refill[s] of certain Prescription Drug Products you obtain through a mail order Network Pharmacy.]</p> <p><i>[Applies only when mail order Copayments and/or Coinsurance in the right hand column are charged for the full 90 day supply. Does not apply when Copayments and/or Coinsurance are tied to the 31, 60 and 90 day supply.]</i></p> <p>[To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.]</p> <p><i>[Applies when plan design includes ¹preferred mail order network pharmacy and/or ²non-preferred mail order</i></p>	<p><i>[There are two copayment and/or coinsurance options. The first is to tie the number of days' supply to the copayment and/or coinsurance level at 31 days, 60 days and 90 days. The second option is to apply a copayment and/or coinsurance, calculated only at the 90-day level, for any number of days' supply of mail order drugs.]</i></p> <p><i>[Variable provision regarding number of days' supply applies only when copayments and/or coinsurance are tied to a number-of-days' supply.]</i></p> <p>[For up to a 31-day supply, we pay:]</p> <p>[For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-75]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-75]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-75]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-75]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[7-35]] [you will not pay more than \$[35-75]] [you will not pay less than \$[7-35] and you will not pay more than \$[35-75]] per Prescription Order or Refill.]]</p> <p>[For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-75]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[5-35]] [you will not pay more than \$[35-75]] [you will not pay less than \$[5-35] and you will not pay more than \$[35-75]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[15-250]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[15-250]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[15-250]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[15-250]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[15-125]] [you will not pay more than \$[125-250]] [you will not pay less than \$[15-125] and you will not pay more than \$[125-250]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-250]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[10-125]] [you will not pay more than \$[125-250]] [you will not pay less than \$[10-125] and you will not pay more than \$[125-250]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[20-450]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after</p>

Description and Supply Limits	Benefit (The Amount We Pay)
<p><i>network pharmacy.</i>³ <i>Applies when plan design includes both preferred and non-preferred mail order network pharmacy.</i></p> <p>[We may designate a mail order Network Pharmacy to be [¹a Preferred Mail Order Network Pharmacy] [³and/or] [²a Non-Preferred Mail Order Network Pharmacy]. We may periodically change the [¹Preferred] [³and/or] [²Non-Preferred] designation of a mail order Network Pharmacy. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you. You may determine whether a mail order Network Pharmacy is a [¹Preferred Mail Order Network Pharmacy] [³or a] [²non-Preferred Mail Order Network Pharmacy] through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p> <p><i>[Applies when plan design includes preferred mail order network pharmacy and copayments and/or coinsurance are reduced for prescription drug products obtained at a preferred pharmacy.]</i></p> <p>[If you use a Preferred Mail Order Network Pharmacy, your Copayment will be reduced by a minimum of \$[1 - 60] per Prescription Order or Refill.]</p> <p>[If you use a Preferred Mail Order Network Pharmacy, your Coinsurance will be reduced by a minimum of \$[1 - 60] per Prescription Order or Refill.]</p> <p>[If you use a Preferred Mail Order Network Pharmacy, your Coinsurance will be reduced by a minimum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.]</p> <p><i>[Applies when plan design includes non-preferred mail order network pharmacy and copayments and/or coinsurance are increased when prescription drug products are obtained at a non-preferred pharmacy.]</i></p> <p>[If you use a Non-Preferred Mail Order Network Pharmacy, your Copayment will be increased by a maximum of \$[1 -</p>	<p>you pay a Copayment of \$[20-450]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[20-450]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[20-450]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[20-225]] [you will not pay more than \$[225-450]] [you will not pay less than \$[20-225] and you will not pay more than \$[225-450]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-450]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[15-225]] [you will not pay more than \$[225-450]] [you will not pay less than \$[15-225] and you will not pay more than \$[225-450]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[70-650]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[70-650]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[70-650]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[70-650]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[70-360]] [you will not pay more than \$[360-650]] [you will not pay less than \$[70-360] and you will not pay more than \$[360-650]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-650]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[50-360]] [you will not pay more than \$[360-650]] [you will not pay less than \$[50-360] and you will not pay more than \$[360-650]] per Prescription Order or Refill.]]</p> <p>[For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[100-750]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[100-750]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[100-750]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[100-750]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[100-425]] [you will not pay more than \$[425-750]] [you will not pay less than \$[100-450] and you will not pay more than \$[425-750]] per Prescription Order or Refill.]]</p> <p>[For a Tier-5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-750]] per Prescription Order or Refill. [[However,] [you</p>

Description and Supply Limits	Benefit (The Amount We Pay)
<p>60] per Prescription Order or Refill.]</p> <p>[If you use a Non-Preferred Mail Order Network Pharmacy, your Coinsurance will be increased by a maximum of \$[1 - 60] per Prescription Order or Refill.]</p> <p>[If you use a Non-Preferred Mail Order Network Pharmacy, your Coinsurance will be increased by a maximum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.]</p>	<p>will not pay less than \$[75-425]] [you will not pay more than \$[425-750]] [you will not pay less than \$[75-425] and you will not pay more than \$[425-750]] per Prescription Order or Refill.]]</p> <p>[For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[150-850]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[150-850]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[150-850]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[150-850]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[150-500]] [you will not pay more than \$[500-850]] [you will not pay less than \$[150-500] and you will not pay more than \$[500-850]] per Prescription Order or Refill.]]</p> <p>[For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-850]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[100-500]] [you will not pay more than \$[500-850]] [you will not pay less than \$[100-500] and you will not pay more than \$[500-850]] per Prescription Order or Refill.]]</p> <p><i>[Variable provision regarding number of days' supply applies only when copayments and/or coinsurance are tied to a number-of-days' supply.]</i></p> <p>[For up to a 60-day supply, we pay:]</p> <p>[For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-150]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-150]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-150]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-150]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[7-70]] [you will not pay more than \$[70-150]] [you will not pay less than \$[7-70] and you will not pay more than \$[70-150]] per Prescription Order or Refill.]]</p> <p>[For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-150]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[5-70]] [you will not pay more than \$[70-150]] [you will not pay less than \$[5-70] and you will not pay more than \$[70-150]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[15-500]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[15-500]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>Class [B] [after you pay a Copayment of \$[15-500]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[15-500]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[15-250]] [you will not pay more than \$[250-500]] [you will not pay less than \$[15-250] and you will not pay more than \$[250-500]] per Prescription Order or Refill.]</p> <p>[For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-500]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[10-250]] [you will not pay more than \$[250-500]] [you will not pay less than \$[10-250] and you will not pay more than \$[250-500]] per Prescription Order or Refill.]</p> <p>[For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[20-900]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[20-900]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[20-900]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[20-900]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[20-450]] [you will not pay more than \$[450-900]] [you will not pay less than \$[20-450] and you will not pay more than \$[450-900]] per Prescription Order or Refill.]</p> <p>[For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-900]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[15-450]] [you will not pay more than \$[450-900]] [you will not pay less than \$[15-450] and you will not pay more than \$[450-900]] per Prescription Order or Refill.]</p> <p>[For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[70-1,300]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[70-1,300]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[70-1,300]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[70-1,300]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[70-720]] [you will not pay more than \$[720-1,300]] [you will not pay less than \$[70-720] and you will not pay more than \$[720-1,300]] per Prescription Order or Refill.]</p> <p>[For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-1,300]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[50-720]] [you will not pay more than \$[720-1,300]] [you will not pay less than \$[50-720] and you will not pay more</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>than \$[720-1,300] per Prescription Order or Refill.]]</p> <p>[For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[100-1,500]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[100-1,500]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[100-1,500]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[100-1,500]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[100-850]] [you will not pay more than \$[850-1,500]] [you will not pay less than \$[100-850] and you will not pay more than \$[850-1,500]] per Prescription Order or Refill.]]</p> <p>[For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-1,500]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[75-850]] [you will not pay more than \$[850-1,500]] [you will not pay less than \$[75-850] and you will not pay more than \$[850-1,500]] per Prescription Order or Refill.]]</p> <p>[For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[150-1,700]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[150-1,700]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[150-1,700]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[150-1,700]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[150-1,000]] [you will not pay more than \$[1,000-1,700]] [you will not pay less than \$[150-1,000] and you will not pay more than \$[1,000-1,700]] per Prescription Order or Refill.]]</p> <p>[For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-1,700]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[100-1,000]] [you will not pay more than \$[1,000-1,700]] [you will not pay less than \$[100-1,000] and you will not pay more than \$[1,000-1,700]] per Prescription Order or Refill.]]</p> <p><i>[Variable provision regarding number of days' supply applies only when copayments and/or coinsurance are tied to a number-of-days' supply.]</i></p> <p>[For up to a 90-day supply, we pay:]</p> <p>[For a Tier 1 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-225]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-225]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-225]]] [, and] [[50-100]% of the</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-225]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[7-105]] [you will not pay more than \$[70-225]] [you will not pay less than \$[7-105] and you will not pay more than \$[70-225]] per Prescription Order or Refill.]</p> <p>[For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-225]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[5-105]] [you will not pay more than \$[70-225]] [you will not pay less than \$[5-105] and you will not pay more than \$[70-225]] per Prescription Order or Refill.]</p> <p>[For a Tier 2 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[15-750]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[15-750]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[15-750]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[15-750]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[15-375]] [you will not pay more than \$[250-750]] [you will not pay less than \$[15-375] and you will not pay more than \$[250-750]] per Prescription Order or Refill.]</p> <p>[For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-750]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[10-375]] [you will not pay more than \$[250-750]] [you will not pay less than \$[10-375] and you will not pay more than \$[250-750]] per Prescription Order or Refill.]</p> <p>[For a Tier 3 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[20-1,350]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[20-1,350]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[20-1,350]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[20-1,350]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[20-675]] [you will not pay more than \$[450-1,350]] [you will not pay less than \$[20-675] and you will not pay more than \$[450-1,350]] per Prescription Order or Refill.]</p> <p>[For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-1,350]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[15-675]] [you will not pay more than \$[450-1,350]] [you will not pay less than \$[15-675] and you will not pay more than \$[450-1,350]] per Prescription Order or Refill.]</p> <p>[For a Tier 4 Prescription Drug Product: [50-100]% of the Prescription</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>Drug Charge [after you pay a Copayment of \$[70-1,950]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[70-1,950]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[70-1,950]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[70-1,950]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[70-1,080]] [you will not pay more than \$[720-1,950]] [you will not pay less than \$[70-1,080] and you will not pay more than \$[720-1,950]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-1,950]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[50-1,080]] [you will not pay more than \$[720-1,950]] [you will not pay less than \$[50-1,080] and you will not pay more than \$[720-1,950]] per Prescription Order or Refill.]]</p> <p>[For a Tier 5 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[100-2,250]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[100-2,250]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[100-2,250]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[100-2,250]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[100-1,275]] [you will not pay more than \$[850-2,250]] [you will not pay less than \$[100-1,275] and you will not pay more than \$[850-2,250]] per Prescription Order or Refill.]]</p> <p>[For a Tier 5 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-2,250]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[75-1,275]] [you will not pay more than \$[850-2,250]] [you will not pay less than \$[75-1,275] and you will not pay more than \$[850-2,250]] per Prescription Order or Refill.]]</p> <p>[For a Tier 6 Prescription Drug Product: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[150-2,550]] per Prescription Order or Refill [, except that we pay [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[150-2,550]]] [,] [and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[150-2,550]]] [, and] [[50-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[150-2,550]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[150-1,500]] [you will not pay more than \$[1,000-2,550]] [you will not pay less than \$[150-1,500] and you will not pay more than \$[1,000-2,550]] per Prescription Order or Refill.]]</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p data-bbox="691 277 1549 457">[For a Tier 6 Prescription Drug Product on the List of Preventive Medications: [50-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-2,550]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[100-1,500]] [you will not pay more than \$[1,000-2,550]] [you will not pay less than \$[100-1,500] and you will not pay more than \$[1,000-2,550]] per Prescription Order or Refill.]</p> <p data-bbox="691 470 889 499">[No Copayment]</p> <p data-bbox="691 516 1563 546"><i>[Applies when closed benefit plan applies.]</i></p> <p data-bbox="691 562 1516 651">[Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or Tier 5] of the Prescription Drug List are not covered.]</p>

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms*.

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

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.]

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the *Certificate*.]

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider, except that Benefits for Prescription Drug Products will be coordinated with prescription drug benefits provided under Medicare [Part B] [Part D] [Parts B and D].]

(Name and Title)

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or [notification] [prior authorization] requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

^[1] Applies when plan design includes the mandatory or restrictive generic program.]

^[2] Applies when plan design includes a therapeutic class charge.]

^[3] Applies when plan design includes a therapeutically equivalent charge.]

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, [¹Ancillary Charge,] [²Therapeutic Class Charge,] [³Therapeutically Equivalent Charge,] and any deductible that applies.

Submit your claim to:

[Name of Pharmacy Benefit Manager]

[Address of Pharmacy Benefit Manager]

[City, State and Zip Code]

[Applies when plan design includes the designated pharmacy program. ¹Applies when plan design includes the specialty drug program.]

[Designated Pharmacies]

[If you require certain Prescription Drug Products¹, including, but not limited to, Specialty Prescription Drug Products,] we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Prescription Drug Product.]

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

[Variable provision below supports plan designs that include an annual drug deductible or a specialty prescription drug annual deductible and plan designs that are combined medical/RX plans.]

¹Applies when rebates are passed on to customers.]

²Applies when rebates are not passed on to customers.]

We may receive rebates for certain drugs included on the Prescription Drug List [, including those drugs that you purchase prior to meeting the [Annual Drug Deductible] [or] [Specialty Prescription Drug Product Annual Deductible]]. [¹We pass [a portion of] [all of] these rebates on to you and they may be [applied to the [Annual Drug Deductible] [or] [Specialty Prescription Drug Product Annual Deductible] [combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your *Certificate*]] [and] taken into account in determining your Copayments and/or Coinsurance, or may be shared with you at point of service or in another manner.] [²We do not pass these rebates on to you, nor are they [applied to the [Annual Drug Deductible] [or] [Specialty Prescription Drug Product Annual Deductible] [combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your *Certificate*]] [or] taken into account in determining your Copayments and/or Coinsurance.]

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Rider*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [\[www.myuhc.com\]](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

[Applies when Rider is issued with combined medical and pharmacy deductible plans and when incentive programs apply.]

[Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans]

[When you are required to meet a combined medical and pharmacy Annual Deductible before we begin to pay Benefits, as stated in the *Schedule of Benefits* attached to your *Certificate*, we may have certain programs in which you may receive an incentive based on your actions such as selecting a Tier 1 or Tier 2 Prescription Drug Product before you have satisfied your combined Annual Deductible. You may access information on these programs through the Internet at [\[www.myuhc.com\]](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.]

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at [\[www.myuhc.com\]](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

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Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Contraceptives are mandated in AR, except for religious group employers. ¹Remove for religious employers who choose to exclude contraceptive coverage.

[Benefits for contraceptives are variable by plan design.]

[¹Applies to plan designs that include closed-panel benefits.]

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service [¹or is prescribed to prevent conception]. [²Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

[Specialty Prescription Drug Products]

[Benefits are provided for Specialty Prescription Drug Products.

[Applies to plan designs that include designated pharmacy.]

[If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Specialty Prescription Drug Product.]

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product [and Designated Pharmacy].

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.]

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Prescription Drugs from a Retail Non-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail non-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with us, as described in your *Certificate, Section 5: How to File a Claim*. We will not reimburse you for the difference between the Predominant Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail non-Network Pharmacy supply limits.

[Applies to plan designs that include mail order.]

[Prescription Drug Products from a Mail Order Network Pharmacy]

[Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on mail order Network Pharmacy supply limits.

Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.]

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* apply also to this Rider, except that any preexisting condition exclusion in the *Certificate* is not applicable to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

[Variable exclusions below are plan design-specific.]

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- [3.] [\[Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.\]](#)
- [4.] Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- [5.] Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven This exclusion will not apply to Prescription Drug Products approved by the *United States Food and Drug Administration (USFDA)* for use in the treatment of cancer on the basis that the Prescription Drug Product has not been approved by the *USFDA* for the treatment of the specific type of cancer for which the Prescription Drug Product has been prescribed, provided:
 - the Prescription Drug Product has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one or more compendia:
 - ◆ *the American Hospital Formulary Service Drug Information;*
 - ◆ *the United States Pharmacopoeia Dispensing Information;* or
 - the Prescription Drug Product has been recognized as safe and effective for treatment of that specific type of cancer in two articles from medical literature that have not had their recognition of the Prescription Drug Product's safety and effectiveness contraindicated by clear and convincing evidence in another article from medical literature.
 - *Medical literature is defined as articles from major peer reviewed medical journals specified by the United States Department of Health and Human Services.*
- [6.] Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- [7.] Prescription Drug Products for any condition, Injury, Sickness or [\[mental illness\]](#) [\[Mental Illness\]](#) arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- [8.] [\[Any product dispensed for the purpose of appetite suppression or weight loss.\]](#)

Contraceptives are mandated in AR, except for religious group employers. ¹Remove for religious employers who choose to exclude contraceptive coverage.

- [8.] A Pharmaceutical Product for which Benefits are provided in your *Certificate*. [¹This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.] [²This exclusion does

not apply to immunizations administered in a [Network] [,] [non-Network] [Network or non-Network] [or] [a Designated] Pharmacy.]

- [10.] Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- [11.] General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- [12.] Unit dose packaging of Prescription Drug Products.
- [13.] Medications used for cosmetic purposes.
- [14.] Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
- [15.] Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- [16.] [Prescription Drug Products when prescribed to treat infertility.]

Include for groups that do not purchase benefits for toenail fungus treatment.

Contraceptives are mandated in AR, except for religious group employers. ¹Include only for religious employers who choose to exclude contraceptive coverage and make corresponding changes to Schedule of Benefits.

- ¹[17.] Prescription Drug Products when prescribed to prevent conception, including, but not limited to, oral contraceptives, diaphragms, Depo Provera and other injectable drugs used for contraception.]
- [18.] [Treatment for toenail Onychomycosis (toenail fungus).]

¹Include for groups that purchase benefits for only certain smoking cessation products.]

- [19.] [[¹Certain] Prescription Drug Products for smoking cessation.]

[Applies when plan design includes closed benefit.]

- [20.] [Prescription Drug Products not included on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4] [or] [Tier 5] of the Prescription Drug List at the time the Prescription Order or Refill is dispensed.]

[Applies when plan design includes closed-panel.]

- [21.] [A Prescription Drug Product prescribed by a non-Network Physician or other non-Network provider.]

¹Applies when plan design includes compounds. ²Applies when plan design excludes compounds.]

- [22.] [¹Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier [2] [3] [4] [5] [6].)] [²Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.]

¹Include when a prescription order/refill is required for coverage. ²Include if group purchases benefits for smoking cessation that include over-the-counter drugs.]

- [23.] [Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product [¹and it is obtained with a Prescription Order or Refill from a Physician]. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously

excluded under this provision. [²This exclusion does not apply to over-the-counter drugs used for smoking cessation.]]

[24.] [Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.]

[¹Applies when plan design excludes growth hormone therapy for all conditions. ²Applies when plan design includes limited benefits for growth hormone therapy.]

[25.] [¹Growth hormone therapy.] [²Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).]

[26.] [Any oral non-sedating antihistamine or antihistamine-decongestant combination.]

[27.] [Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.]

[28.] Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, **except that Medical Foods and Low Protein Food Products are covered for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias and disorders of amino acid metabolism if the products are prescribed and administered under the direction of a Physician.**

[29.] [A particular Therapeutic Class or Therapeutic Classes. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Therapeutic Class or Therapeutic Classes are excluded.]

[30.] [Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.]

[31.] [Prescription Drug Products when prescribed as sleep aids.]

[32.] [A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.]

[33.] [A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.]

[34.] Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

Section 3: Defined Terms

[Variable definitions below are plan design-specific.]

[Applies to plan designs that include the mandatory or restrictive generic program.]

[¹Applies to the mandatory generic program.]

Ancillary Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your [¹or the provider's] request, when a Chemically Equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available on the lower tier. For Prescription Drug Products from non-Network Pharmacies, the Ancillary Charge is calculated as the difference between the Predominant Reimbursement Rate or Maximum Allowable Cost (MAC) List price for non-Network Pharmacies for the Prescription Drug Product on the higher tier, and the Predominant Reimbursement Rate or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available on the lower tier.]

Annual Drug Deductible - the amount you are required to pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and Tier 6]] Prescription Drug Products in a year before we begin paying for Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Drug Deductible applies.]

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products[, including, but not limited to, Specialty Prescription Drug Products]. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.]

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Infertility - failure to achieve a Pregnancy after a year of regular unprotected intercourse if the woman is under age 35, or after six months if the woman is over age 35. In addition, in order to be eligible for Benefits, the Covered Person must also:

- Be under age 44, if female.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.]

Infertility Annual Maximum Benefit - the maximum amount we will pay for covered Prescription Drug Products for Infertility during a year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Infertility Annual Maximum Benefit applies.]

Infertility Maximum Policy Benefit - the maximum amount we will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Policy. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Infertility Maximum Policy Benefit applies.]

[¹Include when plan design includes specialty prescription drug program]

[List of Preventive Medications - a list that identifies certain Prescription Drug Products [¹, which may include certain Specialty Prescription Drug Products,] on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may obtain the List of Preventive Medications through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Maximum Allowable Amount - the maximum amount that should be paid for covered Prescription Drug Products in a Therapeutic Class. This amount is subject to our periodic review and modification and varies by Therapeutic Class.]

[Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our periodic review and modification.]

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

[Non-Preferred Mail Order Network Pharmacy - a mail order pharmacy that we identify as a non-preferred pharmacy within the Network.]

[Non-Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a non-preferred pharmacy within the Network.]

[Out-of-Pocket Drug Maximum - the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Out-of-Pocket Drug Maximum applies.]

Predominant Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. We calculate the Predominant Reimbursement Rate using our Prescription Drug Charge that applies for that particular Prescription Drug Product at most Network Pharmacies.

[Preferred Mail Order Network Pharmacy - a mail order pharmacy that we identify as a preferred pharmacy within the Network.]

[Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network.]

[Applies when plan design includes mail order and MAC pricing.]

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy. [The Prescription Drug Charge for a Generic Prescription Drug Product dispensed by a mail order Network Pharmacy, however, will be the Maximum Allowable Cost (MAC) List price which may be higher or lower than the rate we have agreed to pay the mail order Network Pharmacy. We establish the Maximum Allowable Cost (MAC) List price. You may access the amount you will pay for a Brand-name or Generic Prescription Drug Product to be dispensed by a retail Network Pharmacy and/or a mail order Network Pharmacy through the Internet at [www.myuhc.com] or by calling *Customer Care* at

the telephone number on your ID card. Depending upon your plan design, the amount you will pay may be a Copayment, Coinsurance or the Prescription Drug Charge.]

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at [\[www.myuhc.com\]](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- [\[Immunizations administered in a pharmacy.\]](#)
- The following diabetic supplies:
 - standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - lancets and lancet devices; and
 - glucose monitors.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

[Preventive Care Medications – the medications that are obtained at a Network Pharmacy [with a Prescription Order or Refill from a Physician] and that are payable at 100% of [the Prescription Drug Cost] [the cost] (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.

[Applies if immunizations are covered under the pharmacy benefit:]

- [\[Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.\]](#)
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.]

You may determine whether a drug is a Preventive Care Medication through the internet at [\[www.myuhc.com\]](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card.]

[Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. [Specialty Prescription Drug Products include certain drugs for Infertility.] [Specialty Prescription Drug Products may include drugs on the List of Preventive Medications.] You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Specialty Prescription Drug Product Annual Deductible - the amount you are required to pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4] [,] [and] [Tier 5] [, and Tier 6]] Specialty Prescription Drug Products in a year before we begin paying for Specialty Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Specialty Prescription Drug Product Annual Deductible applies.]

[Specialty Prescription Drug Product Out-of-Pocket Maximum - the maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Specialty Prescription Drug Product Out-of-Pocket Maximum applies.]

[Therapeutic Class - a group or category of Prescription Drug Products with similar uses and/or actions.]

[Therapeutic Class Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product that is dispensed at your or your provider's request is in a Therapeutic Class where we have determined a Maximum Allowable Amount. For Prescription Drug Products from Network Pharmacies, the Therapeutic Class Charge is calculated as the difference between the Prescription Drug Charge for Network Pharmacies for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutic Class. For Prescription Drug Products from non-Network Pharmacies, the Therapeutic Class Charge is calculated as the difference between the Predominant Reimbursement Rate for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutic Class.]

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

[Therapeutically Equivalent Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product that is dispensed at your or your provider's request is Therapeutically Equivalent to a Prescription Drug Product where we have determined a Maximum Allowable Amount. For Prescription Drug Products from Network Pharmacies, the Therapeutically Equivalent Charge is calculated as the difference between the Prescription Drug Charge for Network Pharmacies for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutically Equivalent Prescription Drug Product. For Prescription Drug Products from non-Network Pharmacies, the Therapeutically Equivalent Charge is calculated as the difference between the Predominant Reimbursement Rate for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutically Equivalent Prescription Drug Product.]

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

Benefits for Prescription Drug Products

¹Include when the only Brand-name coverage is for diabetic supplies and insulin.

²Include when Brand-name coverage is available for diabetic supplies and insulin, as well as for at least one other state mandated drug.

Benefits are available for Generic Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Generic Prescription Drug Product is listed. Benefits are also available for [¹Brand-name diabetic supplies and insulin.] [²the following:]

¹Remove for religious employers who choose to exclude contraceptive coverage.

- Brand-name diabetic supplies and insulin.
- [¹Brand-name contraceptives.]

Include for groups that purchase closed-panel benefits and the corresponding exclusion is included in Section 2. (Closed panel means that we pay only for drugs that are prescribed by a Network provider.)

[Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

¹Remove for religious employers who choose to exclude contraceptive coverage.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service [¹or is prescribed to prevent conception].

If a Brand-name Drug Becomes Available as a Generic

If a Prescription Drug Product becomes available as a Generic, Benefits for that Prescription Drug Product may become available to you under this Rider. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

The terms "generic" and "brand-name" are used in the health care industry in many different ways. To be sure that you know whether a drug is classified as Brand-name or Generic by us, please review the definitions contained in Section 3: *Defined Terms*. You should also check the current classification on the Prescription Drug List through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per

Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

[Variable references here and throughout are used to support either notification or prior authorization requirements.]

[Notification] [Prior Authorization] Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to [\[notify\]](#) [\[obtain prior authorization from\]](#) us or our designee. The reason for [\[notifying\]](#) [\[obtaining prior authorization from\]](#) us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to [\[notify\]](#) [\[obtain prior authorization from\]](#) us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy [Notification] [Prior Authorization]

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for [\[notifying\]](#) [\[obtaining prior authorization from\]](#) us.

Non-Network Pharmacy [Notification] [Prior Authorization]

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for [\[notifying\]](#) [\[obtaining prior authorization from\]](#) us as required.

If [\[we are not notified\]](#) [\[you do not obtain prior authorization from us\]](#) before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring [\[notification\]](#) [\[prior authorization\]](#) are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires [\[notification\]](#) [\[prior authorization\]](#) through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

If [\[we are not notified\]](#) [\[you do not obtain prior authorization from us\]](#) before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

[Therapeutic class charge and therapeutically equivalent charge (here and throughout) is variable by plan design.]

When you submit a claim on this basis, you may pay more because you did not [\[notify\]](#) [\[obtain prior authorization from\]](#) us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance [\[, Therapeutic Class Charge\]](#) [\[, Therapeutically Equivalent Charge\]](#) and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require [notification] [prior authorization] for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable [notification] [prior authorization], participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

[Step Therapy]

[Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products for which Benefits are described in your *Certificate* are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

What You Must Pay

[The following bracketed provisions are variable based upon plan design.]

[You are responsible for paying the Annual Drug Deductible.]

[Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.]

[Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.]

[Benefits for [insulin] [or] [diabetic supplies] are not subject to payment of the Annual Drug Deductible.]

[You are responsible for paying the Annual Deductible stated in the *Schedule of Benefits* which is attached to your *Certificate* before Benefits for Prescription Drug Products under this Rider are available to you.]

[Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Deductible.]

[Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.]

[Benefits for [insulin] [or] [diabetic supplies] are not subject to payment of the Annual Deductible.]

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table [, in addition to any [Therapeutic Class Charge] [or] [Therapeutically Equivalent Charge]. [You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.]

[A Therapeutic Class Charge may apply when the Prescription Drug Charge or the Predominant Reimbursement Rate of the Prescription Drug Product exceeds the Maximum Allowable Amount. You are responsible for the Therapeutic Class Charge and any applicable Copayment and/or Coinsurance.]

[A Therapeutically Equivalent Charge may apply when the Prescription Drug Charge or the Predominant Reimbursement Rate of the Prescription Drug Product exceeds the Maximum Allowable Amount. You are responsible for the Therapeutically Equivalent Charge and any applicable Copayment and/or Coinsurance.]

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in your *Certificate*:

- [Copayments for Prescription Drug Products [, including Specialty Prescription Drug Products].]
- [Coinsurance for Prescription Drug Products [, including Specialty Prescription Drug Products].]
- [Therapeutic Class Charges.]

- [\[Therapeutically Equivalent Charges.\]](#)
- [\[The Annual Drug Deductible.\]](#)
- The difference between the Predominant Reimbursement Rate and a non-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

[The following provisions are plan design variable.]

[The Annual Drug Deductibles are calculated on a [calendar] [Policy] year basis.]

[The Out-of-Pocket Drug Maximums are calculated on a [calendar] [Policy] year basis.]

[The Specialty Prescription Drug Product Out-of-Pocket Maximums are calculated on a [calendar] [Policy] year basis.]

Note to Filer - Only include this option if your state mandates coverage for infertility and allows an infertility annual maximum benefit. Remove this instruction before filing.

[The Infertility Annual Maximum Benefit is calculated on a [calendar] [Policy] year basis.]

Payment Term And Description	Amounts
[Annual Drug Deductible]	
<p><i>[Annual drug deductible is plan design variable.]</i></p> <p><i>[Option 1: Applies when the annual drug deductible is determined based on network or non-network status.]</i></p> <p>[The amount you pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4]] Prescription Drug Products [at a Network Pharmacy] [at a non-Network Pharmacy] [at a Network or non-Network Pharmacy] in a year before we begin paying for Prescription Drug Products.]</p> <p><i>[Option 2: Applies when the annual drug deductible is determined based on tier status.]</i></p> <p>[The amount you pay for covered [[Tier 1] [,] [Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4]] Prescription Drug Products [at a Network Pharmacy] [at a non-Network Pharmacy] [at a Network or non-Network Pharmacy] [in a year before we begin paying for Prescription Drug Products.]</p> <p>[Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.]</p> <p>[Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.]</p> <p>[Benefits for [insulin] [or] [diabetic supplies] are not subject to payment of the Annual Drug Deductible.]</p>	<p><i>[The variables below correspond with Option 1.]</i></p> <p>[Network]</p> <p>[No Annual Drug Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p>[Non-Network]</p> <p>[No Annual Drug Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p>[Network and Non-Network]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p><i>[The variables below correspond with Option 2.]</i></p> <p>[Tier 1]</p> <p>[No Annual Drug Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p>[Tier 2]</p> <p>[No Annual Drug Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p>

Payment Term And Description	Amounts
<p><i>[¹Applies when only the individual portion is subject to the annual drug deductible.]</i></p> <p>[Any amount you pay that is applied to the Annual Drug Deductible in the last quarter of the previous [calendar] [Policy] year will be carried over and applied to the current Annual Drug Deductible. [¹This carry-over feature applies only to the individual Annual Drug Deductible.]]</p> <p>[When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual drug deductible provision of the prior policy will apply to the Annual Drug Deductible provision under the Policy.]</p> <p><i>[Applies when the roll-over provision applies to a group changing from a calendar year to policy year plan. ¹Applies when only the individual portion is subject to the annual drug deductible.]</i></p> <p>[When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for Prescription Drug Product expenses in the last three months of the previous calendar year that is applied to the previous Annual Drug Deductible, will be rolled over and applied to the current Policy year Annual Drug Deductible. This roll-over feature applies only to the first Policy year. [¹This roll-over feature applies only to the individual Annual Drug Deductible.]]</p> <p>[Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>	<p><i>[Tier 3]</i></p> <p>[No Annual Drug Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p><i>[Tier 4]</i></p> <p>[No Annual Drug Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p> <p><i>[Tiers [1] [,] [and] [2] [,] [and] [3] [,] [and] [4]</i></p> <p>[No Annual Drug Deductible.]</p> <p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[200 - 3,000] for all Covered Persons in a family.]</p>
<p>[Out-of-Pocket Drug Maximum]</p>	
<p><i>[Out-of-pocket drug maximum is plan design variable. Include applicable]</i></p>	<p><i>[Insert maximum amounts according to benefit design chosen by group.]</i></p> <p><i>[¹Include if copayments and coinsurance are not subject to an out-of-</i></p>

Payment Term And Description	Amounts
<p><i>provisions to support the following:]</i></p> <p><i>[¹The out-of-pocket drug maximum applies annually.]</i></p> <p><i>[²The annual out-of-pocket drug maximum includes copayments.]</i></p> <p><i>[³The annual out-of-pocket drug maximum does not include copayments.]</i></p> <p><i>[⁴The out-of-pocket drug maximum applies monthly.]</i></p> <p><i>[⁵The monthly out-of-pocket drug maximum includes copayments.]</i></p> <p><i>[⁶The monthly out-of-pocket drug maximum does not include copayments.]</i></p> <p><i>[¹The maximum amount you are required to pay for covered Prescription Drug Products in a single year. Once you reach the Out-of-Pocket Drug Maximum, you will not be required to pay [²Copayments or] Coinsurance for covered Prescription Drug Products for the remainder of the year. [³The Out-of-Pocket Drug Maximum does not include Copayments.]]</i></p> <p><i>[⁴The maximum amount you are required to pay for covered Prescription Drug Products in a single calendar month. Once you reach the Out-of-Pocket Drug Maximum, you will not be required to pay [⁵Copayments or] Coinsurance for covered Prescription Drug Products for the remainder of the calendar month. [⁶The Out-of-Pocket Drug Maximum does not include Copayments.]]</i></p> <p><i>[Copayments and Coinsurance for covered Specialty Prescription Drug Products are not limited by the Out-of-Pocket Drug Maximum.]</i></p> <p><i>Include when Infertility is mandated and Copayments and Coinsurance for Infertility drugs do not apply to the OOPDM.</i></p> <p><i>[Copayments and Coinsurance for covered Prescription Drug Products for Infertility are not limited by the Out-of-</i></p>	<p><i>pocket drug maximum.]</i></p> <p><i>[²Include if copayments and/or coinsurance are subject to an out-of-pocket drug maximum and the benefit design includes an annual drug deductible.]</i></p> <p><i>[³If an annual drug deductible applies, select the appropriate statement about whether or not the annual drug deductible applies to the out-of-pocket drug maximum.]</i></p> <p>[Network]</p> <p><i>[Include when individual out-of-pocket drug maximum applies.]</i></p> <p><i>[\$500 - 10,000] per Covered Person.]</i></p> <p><i>[Include when individual (with family maximum) out-of-pocket drug maximum applies.]</i></p> <p><i>[\$500 - 10,000] per Covered Person, not to exceed \$[1,000 - 30,000] for all Covered Persons in a family.]</i></p> <p><i>[¹Copayments and Coinsurance for Prescription Drug Products are not limited by an Out-of-Pocket Drug Maximum.]</i></p> <p><i>[²The Out-of-Pocket Drug Maximum [³includes] [³does not include] the Annual Drug Deductible.]</i></p> <p>[Non-Network]</p> <p><i>[Include when individual out-of-pocket drug maximum applies.]</i></p> <p><i>[\$500 - 10,000] per Covered Person.]</i></p> <p><i>[Include when individual (with family maximum) out-of-pocket drug maximum applies.]</i></p> <p><i>[\$500 - 10,000] per Covered Person, not to exceed \$[1,000 - 30,000] for all Covered Persons in a family.]</i></p> <p><i>[¹Copayments and Coinsurance for Prescription Drug Products are not limited by an Out-of-Pocket Drug Maximum.]</i></p> <p><i>[²The Out-of-Pocket Drug Maximum [³includes] [³does not include] the Annual Drug Deductible.]</i></p> <p>[Network and Non-Network]</p> <p><i>[Include when individual out-of-pocket drug maximum applies.]</i></p> <p><i>[\$500 - 10,000] per Covered Person.]</i></p> <p><i>[Include when individual (with family maximum) out-of-pocket drug maximum applies.]</i></p> <p><i>[\$500 - 10,000] per Covered Person, not to exceed \$[1,000 - 30,000] for all Covered Persons in a family.]</i></p> <p><i>[²The Out-of-Pocket Drug Maximum [³includes] [³does not include] the Annual Drug Deductible.]</i></p>

Payment Term And Description	Amounts
Pocket Drug Maximum.]	
[Specialty Prescription Drug Product Out-of-Pocket Maximum]	
<p><i>[Specialty out-of-pocket maximum is plan design variable. Include applicable provisions to support the following:]</i></p> <p><i>[¹The specialty out-of-pocket maximum applies annually.]</i></p> <p><i>[²The specialty annual out-of-pocket maximum includes copayments.]</i></p> <p><i>[³The specialty annual out-of-pocket maximum does not include copayments.]</i></p> <p><i>[⁴The specialty out-of-pocket maximum applies monthly.]</i></p> <p><i>[⁵The specialty monthly out-of-pocket maximum includes copayments.]</i></p> <p><i>[⁶The specialty monthly out-of-pocket maximum does not include copayments.]</i></p> <p><i>[¹The maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single year. Once you reach the Specialty Prescription Drug Product Out-of-Pocket Maximum, you will not be required to pay [²Copayments or] Coinsurance for covered Specialty Prescription Drug Products for the remainder of the year. [³The Specialty Prescription Drug Product Out-of-Pocket Maximum does not include Copayments.]]</i></p> <p><i>[⁴The maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single calendar month. Once you reach the Specialty Prescription Drug Product Out-of-Pocket Maximum, you will not be required to pay [⁵Copayments or] Coinsurance for covered Specialty Prescription Drug Products for the remainder of the calendar month. [⁶The Specialty Prescription Drug Product Out-of-Pocket Maximum does not include Copayments.]]</i></p> <p><i>Include when Infertility is mandated and Copayments and Coinsurance for</i></p>	<p><i>[Specialty Prescription Drug Product]</i></p> <p><i>[Include when individual specialty out-of-pocket maximum applies.]</i></p> <p><i>[\$[500 - 10,000] for Specialty Prescription Drug Products per Covered Person.] [This does not include any maximum stated below.]</i></p> <p><i>[Include when individual (with family maximum) specialty out-of-pocket maximum applies.]</i></p> <p><i>[\$[500 - 10,000] for Specialty Prescription Drug Products per Covered Person, not to exceed \$[1,000 - 30,000] for all Covered Persons in a family.] [This does not include any maximum stated below.]</i></p> <p><i>[This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Annual Drug Deductible.]</i></p> <p><i>[Copayments and Coinsurance for covered Specialty Prescription Drug Products are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.]</i></p> <p><i>[Specialty - Per Specialty Prescription Drug Product]</i></p> <p><i>[\$[500 - 10,000] per Specialty Prescription Drug Product per Covered Person.] [This does not include any maximum stated below.]</i></p> <p><i>[\$[500 - 10,000] per Specialty Prescription Drug Product per Covered Person, not to exceed \$[1,000 - 30,000] per Specialty Prescription Drug Product for all Covered Persons in a family.] [This does not include any maximum stated below.]</i></p> <p><i>[This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Annual Drug Deductible.]</i></p> <p><i>[Specialty - per Therapeutic Class]</i></p> <p><i>[\$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class A per Covered Person.]</i></p> <p><i>[\$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class A per Covered Person, not to exceed \$[1,000 - 30,000] for all Covered Persons in a family.]</i></p> <p><i>[Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class A are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.]</i></p> <p><i>[This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Annual Drug Deductible.]</i></p> <p><i>[\$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class B per Covered Person.]</i></p> <p><i>[\$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class B per Covered Person, not to exceed \$[1,000 - 30,000] for all Covered Persons in a family.]</i></p>

Payment Term And Description	Amounts
<p><i>Infertility drugs do not apply to the OOPDM.</i></p> <p>[Copayments and Coinsurance for covered Specialty Prescription Drug Products for Infertility are not limited by the Specialty Prescription Drug Product Out-of-Pocket Maximum.]</p>	<p>[Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class B are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.]</p> <p>[This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Annual Drug Deductible.]</p> <p>[\$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class C per Covered Person.]</p> <p>[\$[500 - 10,000] for Specialty Prescription Drug Products in Therapeutic Class C per Covered Person, not to exceed \$[1,000 - 30,000] for all Covered Persons in a family.]</p> <p>[Copayments and Coinsurance for covered Specialty Prescription Drug Products in Therapeutic Class C are not limited by a Specialty Prescription Drug Product Out-of-Pocket Maximum.]</p> <p>[This Specialty Prescription Drug Product Out-of-Pocket Maximum [includes] [does not include] the Annual Drug Deductible.]</p>
<p><i>Note to Filer - Only include this option if your state mandates coverage for infertility and allows an annual maximum. Remove this instruction before filing.</i></p> <p>[Infertility Annual Maximum Benefit]</p>	
<p>[The maximum amount we will pay for covered Prescription Drug Products for Infertility during a year.]</p>	<p>[\$[250 - 10,000] per Covered Person.]</p>
<p><i>Note to Filer - Only include this option if your state mandates coverage for infertility and a separate Infertility Maximum Policy Benefit is allowed. Remove this instruction before filing.</i></p> <p>[Infertility Maximum Policy Benefit]</p>	
<p>[The maximum amount we will pay for covered Prescription Drug Products for Infertility during the entire period of time you are enrolled for coverage under the Policy.]</p>	<p>[\$[250 - 10,000] per Covered Person.]</p>
<p>[Specialty Prescription Drug Product Maximum Policy Benefit]</p>	
<p><i>[Applicability of specialty prescription drug product maximum policy benefit is plan design variable.]</i></p> <p>[The maximum amount we will pay for covered Specialty Prescription Drug Products during the entire period of time you are enrolled for coverage under the</p>	<p>[\$[250 - 10,000] per Covered Person.]</p>

Payment Term And Description	Amounts
Policy.]	
Copayment and Coinsurance	
<p>Copayment Copayment for a Prescription Drug Product at a Network or non-Network Pharmacy is a specific dollar amount.</p> <p>Coinsurance Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate.</p> <p>Copayment and Coinsurance Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. [Your Copayment and/or Coinsurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable [notification] [prior authorization] participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p> <p>Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number</p>	<p>[¹Applies when our negotiated rate does not apply.] [²Applies when our negotiated rate applies.]</p> <p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the [¹lower] [²lowest] of the following:</p> <ul style="list-style-type: none"> • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • [²The Prescription Drug Charge for that Prescription Drug Product.] <p>[For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> • The applicable Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product.] <p>See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. [You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.]</p>

Payment Term And Description	Amounts
<p>on your ID card.</p> <p>Prescription Drug Products Prescribed by a Specialist Physician: You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card for the most up-to-date tier status.</p> <p>[Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
<p><i>[The specialty prescription drug product benefit description is plan design variable.]</i></p> <p>[Specialty Prescription Drug Products]</p>	
<p>[The following supply limits apply.]</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive [31] [60]-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. <p>When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive [31]-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p> <p>Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy [,] [or] a non-Network Pharmacy [,] [or] [a mail order Network Pharmacy] [or] [a Designated Pharmacy].]</p>	<p><i>[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of preventive medications.]</i></p> <p>[Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4]. Please access [www.myuhc.com] through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.]</p> <p>[Network Pharmacy]</p> <p>[For a Tier 1 Specialty Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-25]]] [,] [and] [[60-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-25]]] [, and] [[60-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-25]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[7-15]] [you will not pay more than \$[15-25]] [you will not pay less than \$[7-15]] and you will not pay more than \$[15-25]] per Prescription Order or Refill.]]</p> <p>[For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[5-15]] [you will not pay more than \$[10-20]] [you will not pay less than \$[5-15]] and you will not pay more than \$[10-20]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Specialty Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-45]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-50]]] [,] [and] [[60-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-50]]] [, and] [[60-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-50]]] per Prescription Order or Refill].</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>[[However,] [you will not pay less than \$[15-35]] [you will not pay more than \$[35-50]] [you will not pay less than \$[15-35] and you will not pay more than \$[35-50]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-45]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[10-35]] [you will not pay more than \$[20-45]] [you will not pay less than \$[10-35] and you will not pay more than \$[20-45]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Specialty Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-85]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-90]]] [,] [and] [[60-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-90]]] [, and] [[60-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-90]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[20-70]] [you will not pay more than \$[70-250]] [you will not pay less than \$[20-70] and you will not pay more than \$[70-250]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-80]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[15-70]] [you will not pay more than \$[30-250]] [you will not pay less than \$[15-70] and you will not pay more than \$[30-250]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Specialty Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-200]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-225]]] [,] [and] [[60-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-225]]] [, and] [[60-100]% of the Prescription Drug Charge for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-225]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[70-150]] [you will not pay more than \$[150-500]] [you will not pay less than \$[70-150] and you will not pay more than \$[150-500]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-175]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[50-100]] [you will not pay more than \$[100-450]] [you will not pay less than \$[50-100] and you will not pay more than \$[100-450]] per Prescription Order or Refill.]]</p> <p>[No Copayment]</p> <p><i>[Non-Network Pharmacy]</i></p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>[For a Tier 1 Specialty Prescription Drug Product: [60-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-25]]] [,] [and] [[60-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-25]]] [, and] [[60-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-25]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[7-15]] [you will not pay more than \$[15-25]] [you will not pay less than \$[7-15] and you will not pay more than \$[15-25]] per Prescription Order or Refill.]]</p> <p>[For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[5-15]] [you will not pay more than \$[10-20]] [you will not pay less than \$[5-15] and you will not pay more than \$[10-20]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Specialty Prescription Drug Product: [60-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-45]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-50]]] [,] [and] [[60-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-50]]] [, and] [[60-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-50]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[15-35]] [you will not pay more than \$[35-50]] [you will not pay less than \$[15-35] and you will not pay more than \$[35-50]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-45]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[10-35]] [you will not pay more than \$[20-45]] [you will not pay less than \$[10-35] and you will not pay more than \$[20-45]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Specialty Prescription Drug Product: [60-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-85]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-90]]] [,] [and] [[60-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-90]]] [, and] [[60-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-90]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[20-</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>70]] [you will not pay more than \$[70-250]] [you will not pay less than \$[20-70] and you will not pay more than \$[70-250]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-80]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[15-70]] [you will not pay more than \$[30-250]] [you will not pay less than \$[15-70] and you will not pay more than \$[30-250]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Specialty Prescription Drug Product: [60-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-200]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-225]]] [,] [and] [[60-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-225]]] [, and] [[60-100]% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-225]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[70-150]] [you will not pay more than \$[150-500]] [you will not pay less than \$[70-150] and you will not pay more than \$[150-500]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-175]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[50-100]] [you will not pay more than \$[100-450]] [you will not pay less than \$[50-100] and you will not pay more than \$[100-450]] per Prescription Order or Refill.]]</p> <p>[No Copayment]</p> <p><i>[Applies when closed benefit plan applies.]</i></p> <p>[Specialty Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] of the Prescription Drug List are not covered.]</p>
<p>Prescription Drugs from a Retail Network Pharmacy</p> <p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. <p><i>[Applies when plan design includes 90 day generic coverage.]</i></p> <ul style="list-style-type: none"> [As written by the provider, a 90-day supply of a Generic for which the Usual and Customary Charge 	<p><i>[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of preventive medications.]</i></p> <p>[Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4]. Please access [www.myuhc.com] through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.]</p> <p>[For a Tier 1 - Prescription Drug Product: [60-100]% of the Prescription</p>

Description and Supply Limits	Benefit (The Amount We Pay)
<p>does not exceed \$[10 - 20].]</p> <p><i>Note to filer - always include without brackets unless your state requires contraceptives to be an optional coverage for religious employers who may choose to exclude contraceptive benefits. If so, include as written below with brackets included. Remove this instruction before filing.</i></p> <ul style="list-style-type: none"> [A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied.] <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p> <p><i>[Applies when plan design includes ¹preferred retail network pharmacy and/or ²non-preferred retail network pharmacy. ³Applies when plan design includes both preferred and non-preferred retail network pharmacy.]</i></p> <p>[We may designate certain retail Network Pharmacies to be [¹a Preferred Retail Network Pharmacy] [³and/or] [²a Non-Preferred Retail Network Pharmacy]. We may periodically change the [¹Preferred] [³and/or] [²Non-Preferred] designation of a retail Network Pharmacy. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you. You may determine whether a retail Network Pharmacy is a [¹Preferred Retail Network Pharmacy] [³or a] [²Non-Preferred Retail Network Pharmacy] through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.]</p> <p><i>[Applies when plan design includes preferred retail network pharmacy and copayments and/or coinsurance are</i></p>	<p>Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-25]]] [,] [and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [¹after you pay a Copayment of \$[0-25]]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-25]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[7-15]] [you will not pay more than \$[15-25]] [you will not pay less than \$[7-15] and you will not pay more than \$[15-25]] per Prescription Order or Refill.]]</p> <p>[For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[5-15]] [you will not pay more than \$[10-20]] [you will not pay less than \$[5-15] and you will not pay more than \$[10-20]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-45]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-50]]] [,] [and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-50]]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-50]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[15-35]] [you will not pay more than \$[35-50]] [you will not pay less than \$[15-35] and you will not pay more than \$[35-50]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-45]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[10-35]] [you will not pay more than \$[20-45]] [you will not pay less than \$[10-35] and you will not pay more than \$[20-45]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-85]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-90]]] [,] [and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-90]]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-90]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[20-70]] [you will not pay more than \$[70-250]] [you will not pay less than \$[20-70] and you will not pay more than \$[70-250]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-80]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[15-70]] [you will not pay more than \$[30-250]]</p>

Description and Supply Limits	Benefit (The Amount We Pay)
<p><i>reduced for prescription drug products obtained at a preferred pharmacy.]</i></p>	<p>[you will not pay less than \$[15-70] and you will not pay more than \$[30-250]] per Prescription Order or Refill.]]</p>
<p>[If you use a Preferred Retail Network Pharmacy, your Copayment will be reduced by a minimum of \$[1 - 60] per Prescription Order or Refill.]</p>	<p>[For a Tier 4 Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-200]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-225]]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-225]]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-225]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[70-150]] [you will not pay more than \$[150-500]] [you will not pay less than \$[70-150] and you will not pay more than \$[150-500]] per Prescription Order or Refill.]]</p>
<p>[If you use a Preferred Retail Network Pharmacy, your Coinsurance will be reduced by a minimum of \$[1 - 60] per Prescription Order or Refill.]</p>	<p>[For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-175]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[50-100]] [you will not pay more than \$[100-450]] [you will not pay less than \$[50-100] and you will not pay more than \$[100-450]] per Prescription Order or Refill.]]</p>
<p>[If you use a Preferred Retail Network Pharmacy, your Coinsurance will be reduced by a minimum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.]</p>	<p>[No Copayment]</p>
<p><i>[Applies when plan design includes non-preferred retail network pharmacy and copayments and/or coinsurance are increased when prescription drug products are obtained at a non-preferred pharmacy.]</i></p>	<p><i>[Applies when closed benefit plan applies.]</i></p>
<p>[If you use a Non-Preferred Retail Network Pharmacy, your Copayment will be increased by a maximum of \$[1 - 60] per Prescription Order or Refill.]</p>	<p>[Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [or] [Tier 3] of the Prescription Drug List are not covered.]</p>
<p>[If you use a Non-Preferred Retail Network Pharmacy, your Coinsurance will be increased by a maximum of \$[1 - 60] per Prescription Order or Refill.]</p>	<p><i>[Include when 90 day generic coverage applies.]</i></p> <p>[For a 90-day supply of a Generic for which the Usual and Customary Charge does not exceed \$[10 - 20], we pay:]</p>
<p>[If you use a Non-Preferred Retail Network Pharmacy, your Coinsurance will be increased by a maximum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.]</p>	<p>[For a Tier 1 Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-20]]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-20]]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-20]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per Prescription Order or Refill.]]</p>
	<p>[For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per Prescription Order or Refill.]]</p>
	<p>[For a Tier 2 Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-20]] [.] [and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-20]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-20]] [.] [and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-20]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-20]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-20]] [.] [and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-20]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-20]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[0-15]] [you will not pay more than \$[0-20]] [you will not pay less than \$[0-15] and you will not pay more than \$[0-20]] per</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>Prescription Order or Refill.]]</p> <p>[No Copayment]</p> <p><i>[Applies when a closed benefit plan applies.]</i></p> <p>[Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] of the Prescription Drug List are not covered.]</p>
<p>Prescription Drugs from a Retail Non-Network Pharmacy</p>	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. <p><i>Note to Filer - always include without brackets unless your state requires contraceptives to be an optional coverage for religious employers who may choose to exclude contraceptive benefits. If so, include the as written with brackets included. Remove this instruction before filing.</i></p> <ul style="list-style-type: none"> [A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied.] <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p>	<p><i>[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments /coinsurance by therapeutic class; and different copayments for drugs on the list of preventive medications.]</i></p> <p>[Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4]. Please access [www.myuhc.com] through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.]</p> <p>[For a Tier 1 Prescription Drug Product: [60-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-25]]] [,] [and] [[60-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-25]]] [, and] [[60-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-25]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[7-15]] [you will not pay more than \$[15-25]] [you will not pay less than \$[7-15] and you will not pay more than \$[15-25]] per Prescription Order or Refill.]]</p> <p>[For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[5-15]] [you will not pay more than \$[10-20]] [you will not pay less than \$[5-15] and you will not pay more than \$[10-20]] per Prescription Order or Refill.]]]</p> <p>[For a Tier 2 Prescription Drug Product: [60-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-45]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-50]]] [,] [and] [[60-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-50]]] [, and] [[60-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-50]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[15-35]] [you will not pay more than \$[35-50]] [you</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>will not pay less than \$[15-35] and you will not pay more than \$[35-50] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-45]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[10-35]] [you will not pay more than \$[20-45]] [you will not pay less than \$[10-35] and you will not pay more than \$[20-45]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Prescription Drug Product: [60-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-85]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-90]]] [,] [and] [[60-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-90]]] [, and] [[60-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-90]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[20-70]] [you will not pay more than \$[70-250]] [you will not pay less than \$[20-70] and you will not pay more than \$[70-250]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-80]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[15-70]] [you will not pay more than \$[30-250]] [you will not pay less than \$[15-70] and you will not pay more than \$[30-250]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Prescription Drug Product: [60-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-200]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-225]]] [,] [and] [[60-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-225]]] [, and] [[60-100]% of the Predominant Reimbursement Rate for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-225]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[70-150]] [you will not pay more than \$[150-500]] [you will not pay less than \$[70-150] and you will not pay more than \$[150-500]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-175]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[50-100]] [you will not pay more than \$[100-450]] [you will not pay less than \$[50-100] and you will not pay more than \$[100-450]] per Prescription Order or Refill.]]</p> <p>[No Copayment]</p> <p><i>[Applies when closed benefit plan applies.]</i></p> <p>[Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [or] [Tier</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	3] of the Prescription Drug List are not covered.]
<p><i>[Applies when plan design includes a mail order benefit.]</i></p> <p>[Prescription Drug Products from a Mail Order Network Pharmacy]</p>	
<p>[The following supply limits apply:</p> <p><i>[¹Applies when plan design includes specialty drug program.]</i></p> <p><i>[²Apply when plan design includes the list of preventive medications.]</i></p> <p>As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. [¹These supply limits do not apply to Specialty Prescription Drug Products², including Specialty Prescription Drug Products on the List of Preventive Medications]. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading <i>Specialty Prescription Drug Products.</i></p> <p><i>[Applies when coverage is initially required at a retail pharmacy prior to using mail order.]</i></p> <p>[You may be required to fill an initial Prescription Drug Product order and obtain [1 - 3] refill[s] through a retail pharmacy prior to using a mail order Network Pharmacy.]</p> <p><i>[Applies when initial mail day supply is limited.]</i></p> <p>[You may be limited to a 31-day supply for your initial fill and [1 - 3] refill[s] of certain Prescription Drug Products you obtain through a mail order Network Pharmacy.]</p> <p><i>[Applies only when mail order copayments and/or coinsurance in the right hand column are charged for the full 90 day supply. Does not apply when copayments and/or coinsurance are tied to the 31, 60 and 90 day supply.]</i></p>	<p><i>[Variable provisions allow for differing coinsurance or copayment by tier. Within each tier, they also allow for the following: differing copayments /coinsurance by therapeutic class; and different copayments for preventive medications.]</i></p> <p>[Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [or Tier 4]. Please access [www.myuhc.com] through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.]</p> <p><i>[There are two copayment and/or coinsurance options. The first is to tie the number of days' supply to the copayment and/or coinsurance level at 31 days, 60 days and 90 days. The second option is to apply a copayment and/or coinsurance, calculated only at the 90-day level, for any number of days' supply of mail order drugs.]</i></p> <p><i>[Variable provision regarding number of days' supply applies only when copayments and/or coinsurance are tied to a number-of-days' supply.]</i></p> <p>[For up to a 31-day supply, we pay:]</p> <p>[For a Tier 1 Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-25]]] [,] [and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-25]]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-25]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[7-15]] [you will not pay more than \$[15-25]] [you will not pay less than \$[7-15] and you will not pay more than \$[15-25]] per Prescription Order or Refill.]]</p> <p>[For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[5-15]] [you will not pay more than \$[10-20]] [you will not pay less than \$[5-15] and you will not pay more than \$[10-20]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-45]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-50]]] [,] [and] [[60-100]% of the Prescription</p>

Description and Supply Limits	Benefit (The Amount We Pay)
<p>[To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.]</p> <p><i>[Applies when plan design includes ¹preferred mail order network pharmacy and/or ²non-preferred mail order network pharmacy. ³Applies when plan design includes both preferred and non-preferred mail order network pharmacy.]</i></p> <p>[We may designate a mail order Network Pharmacy to be [¹a Preferred Mail Order Network Pharmacy] [³and/or] [²a Non-Preferred Mail Order Network Pharmacy]. We may periodically change the [¹Preferred] [³and/or] [²Non-Preferred] designation of a mail order Network Pharmacy. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you. You may determine whether a mail order Network Pharmacy is a [¹Preferred Mail Order Network Pharmacy] [³or a] [²non-Preferred Mail Order Network Pharmacy] through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p> <p><i>[Applies when plan design includes preferred mail order network pharmacy and copayments and/or coinsurance are reduced for prescription drug products obtained at a preferred pharmacy.]</i></p> <p>[If you use a Preferred Mail Order Network Pharmacy, your Copayment will be reduced by a minimum of \$[1 - 60] per Prescription Order or Refill.]</p> <p>[If you use a Preferred Mail Order Network Pharmacy, your Coinsurance will be reduced by a minimum of \$[1 -</p>	<p>Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-50]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-50]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[15-35]] [you will not pay more than \$[35-50]] [you will not pay less than \$[15-35] and you will not pay more than \$[35-50]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-45]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[10-35]] [you will not pay more than \$[20-45]] [you will not pay less than \$[10-35] and you will not pay more than \$[20-45]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-85]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-90]]] [,] [and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-90]]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-90]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[20-70]] [you will not pay more than \$[70-250]] [you will not pay less than \$[20-70] and you will not pay more than \$[70-250]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-80]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[15-70]] [you will not pay more than \$[30-250]] [you will not pay less than \$[15-70] and you will not pay more than \$[30-250]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-200]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-225]]] [,] [and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-225]]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-225]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[70-150]] [you will not pay more than \$[150-500]] [you will not pay less than \$[70-150] and you will not pay more than \$[150-500]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-175]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[50-100]] [you will not pay more than \$[100-450]] [you will not pay less than \$[50-100] and you will not pay more than \$[100-450]] per Prescription Order or Refill.]]</p> <p><i>[Variable provision regarding number of days' supply applies only when</i></p>

Description and Supply Limits	Benefit (The Amount We Pay)
<p>60] per Prescription Order or Refill.]</p> <p>[If you use a Preferred Mail Order Network Pharmacy, your Coinsurance will be reduced by a minimum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.]</p> <p><i>[Applies when plan design includes non-preferred mail order network pharmacy and copayments and/or coinsurance are increased when prescription drug products are obtained at a non-preferred pharmacy.]</i></p> <p>[If you use a Non-Preferred Mail Order Network Pharmacy, your Copayment will be increased by a maximum of \$[1 - 60] per Prescription Order or Refill.]</p> <p>[If you use a Non-Preferred Mail Order Network Pharmacy, your Coinsurance will be increased by a maximum of \$[1 - 60] per Prescription Order or Refill.]</p> <p>[If you use a Non-Preferred Mail Order Network Pharmacy, your Coinsurance will be increased by a maximum of [0 - 50]% of the Prescription Drug Charge per Prescription Order or Refill.]</p>	<p><i>copayments and/or coinsurance are tied to a number-of-days' supply.]</i></p> <p>[For up to a 60-day supply, we pay:]</p> <p>[For a Tier 1 Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-40]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-50]]] [,] [and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-50]]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-50]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[14-30]] [you will not pay more than \$[30-50]] [you will not pay less than \$[14-30] and you will not pay more than \$[30-50]] per Prescription Order or Refill.]]</p> <p>[For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-40]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[10-30]] [you will not pay more than \$[20-40]] [you will not pay less than \$[10-30] and you will not pay more than \$[20-40]]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-90]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-100]]] [,] [and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-100]]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-100]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[30-70]] [you will not pay more than \$[70-100]] [you will not pay less than \$[30-70] and you will not pay more than \$[70-100]]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-90]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[20-70]] [you will not pay more than \$[40-90]] [you will not pay less than \$[20-70] and you will not pay more than \$[40-90]]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-170]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-180]]] [,] [and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-180]]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-180]]] per Prescription Order or Refill]. [[However,] [you will not pay less than \$[40-140]] [you will not pay more than \$[140-500]] [you will not pay less than \$[40-140] and you</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>will not pay more than \$[140-500]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-160]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[30-140]] [you will not pay more than \$[60-500]] [you will not pay less than \$[30-140] and you will not pay more than \$[60-500]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-400]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-450]]] [,] [and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-450]]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-450]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[140-300]] [you will not pay more than \$[300-1,000]] [you will not pay less than \$[140-300] and you will not pay more than \$[300-1,000]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-350]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[100-200]] [you will not pay more than \$[200-900]] [you will not pay less than \$[100-200] and you will not pay more than \$[200-900]] per Prescription Order or Refill.]]</p> <p><i>[Variable provision regarding number of days' supply applies only when copayments and/or coinsurance are tied to a number-of-days' supply.]</i></p> <p>[For up to a 90-day supply, we pay:]</p> <p>[For a Tier 1 Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-60]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-75]]] [,] [and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-75]]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-75]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[14-45]] [you will not pay more than \$[30-75]] [you will not pay less than \$[14-45] and you will not pay more than \$[30-75]] per Prescription Order or Refill.]]</p> <p>[For a Tier 1 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-60]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[10-45]] [you will not pay more than \$[20-60]] [you will not pay less than \$[10-45] and you will not pay more than \$[20-60]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-135]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-150]] [.] [and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-150]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-150]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[30-105]] [you will not pay more than \$[70-150]] [you will not pay less than \$[30-105] and you will not pay more than \$[70-150]] per Prescription Order or Refill.]]</p> <p>[For a Tier 2 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-135]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[20-105]] [you will not pay more than \$[40-135]] [you will not pay less than \$[20-105] and you will not pay more than \$[40-135]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-255]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-270]] [.] [and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-270]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-270]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[40-210]] [you will not pay more than \$[140-750]] [you will not pay less than \$[40-210] and you will not pay more than \$[140-750]] per Prescription Order or Refill.]]</p> <p>[For a Tier 3 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-240]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[30-210]] [you will not pay more than \$[60-750]] [you will not pay less than \$[30-210] and you will not pay more than \$[60-750]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Prescription Drug Product: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-600]] per Prescription Order or Refill [, except that we pay [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [A] [after you pay a Copayment of \$[0-675]] [.] [and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [B] [after you pay a Copayment of \$[0-675]] [, and] [[60-100]% of the Prescription Drug Charge for a Prescription Drug Product for Therapeutic Class [C] [after you pay a Copayment of \$[0-675]]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[140-450]] [you will not pay more than \$[300-1,500]] [you will not pay less than \$[140-450] and you will not pay more than \$[300-1,500]] per Prescription Order or Refill.]]</p> <p>[For a Tier 4 Prescription Drug Product on the List of Preventive Medications: [60-100]% of the Prescription Drug Charge [after you pay a Copayment of \$[0-525]] per Prescription Order or Refill. [[However,] [you will not pay less than \$[100-300]] [you will not pay more than \$[200-1,350]] [you will not pay less than \$[100-300] and you will not pay more</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>than \$[200-1,350]] per Prescription Order or Refill.]]</p> <p>[No Copayment]</p> <p><i>[Applies when closed benefit plan applies.]</i></p> <p>[Prescription Drug Products that are not on Tier 1 [,] [or] [Tier 2] [or] [Tier 3] of the Prescription Drug List are not covered.]</p>

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

¹Include when the only Brand-name coverage is for diabetic supplies and insulin.

²Include when Brand-name coverage is available for diabetic supplies and insulin, as well as for at least one other state mandated drug.

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for outpatient Generic Prescription Drug Products. All references to Benefits for Prescription Drug Products in this Rider and the attached *Schedule of Benefits* refer to Benefits only for Generic Prescription Drug Products unless otherwise explicitly noted. This Rider does not provide Benefits for Brand-name Prescription Drug Products¹, except for Brand-name diabetic supplies and insulin.] ²except for the following as required by state law:]

¹Remove for religious employers who choose to exclude contraceptive coverage.

- Brand-name diabetic supplies and insulin.
- [¹Brand-name contraceptives.]

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms*.

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

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.]

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the *Certificate*.]

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider, except that Benefits for Prescription Drug Products will be coordinated with prescription drug benefits provided under Medicare [Part B] [Part D] [Parts B and D].]

(Name and Title)

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or [notification] [prior authorization] requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others, therefore a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

[¹Applies when the plan design includes a therapeutic class charge.]

[²Applies when the plan design includes a therapeutically equivalent charge.]

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance [¹,Therapeutic Class Charge,] [²Therapeutically Equivalent Charge,] and any deductible that applies.

Submit your claim to:

[Name of Pharmacy Benefit Manager]

[Address of Pharmacy Benefit Manager]

[City, State and Zip Code]

[Applies when the plan design includes the designated pharmacy program. ¹Applies when the plan design includes the specialty drug program.]

[Designated Pharmacies]

[If you require certain Prescription Drug Products [¹, including, but not limited to, Specialty Prescription Drug Products,] we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Prescription Drug Product.]

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

[Variable provision below supports plan designs that include an annual drug deductible and plan designs that are combined medical/RX plans.]

[¹Applies when rebates are passed on to customers.]

[²Applies when rebates are not passed on to customers.]

We may receive rebates for certain drugs included on the Prescription Drug List [, including those drugs that you purchase prior to meeting the Annual Drug Deductible]. [¹We pass [a portion of] [all of] these rebates on to you, and they may be [applied to the [Annual Drug Deductible] [combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your *Certificate*]] [and] taken into account in determining your Copayments and/or Coinsurance, or may be shared with you at point of service or in another manner.]

[²We do not pass these rebates on to you, nor are they [applied to the [Annual Drug Deductible] [combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your *Certificate*]] [or] taken into account in determining your Copayments and/or Coinsurance.]

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Rider*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

[Applies when Rider is issued with combined medical and pharmacy deductible plans and when incentive programs apply.]

[Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans]

[When you are required to meet a combined medical and pharmacy Annual Deductible before we begin to pay Benefits, as stated in the *Schedule of Benefits* attached to your *Certificate*, we may have certain programs in which you may receive an incentive based on your actions such as selecting a Tier 1 or Tier 2 Prescription Drug Product before you have satisfied your combined Annual Deductible. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Outpatient Prescription Drug Rider Table of Contents

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Section 1: Benefits for Prescription Drug Products

Benefits are available for Generic Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

¹*Remove for religious employers who choose to exclude contraceptive coverage.*

²*Include for group that purchase closed-panel benefits and the corresponding exclusion is included in Section 2. (Closed panel means that we pay only for drugs that are prescribed by a Network provider.)*

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service [¹or is prescribed to prevent conception]. [²Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

[Specialty Prescription Drug Products]

[Benefits are provided for Specialty Prescription Drug Products.

[Applies to plan designs that include designated pharmacy.]

[If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Specialty Prescription Drug Product.]

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product [¹and Designated Pharmacy].

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.]

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Prescription Drugs from a Retail Non-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail non-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with us, as described in your *Certificate, Section 5: How to File a Claim*. We will not reimburse you for the difference between the Predominant Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail non-Network Pharmacy supply limits.

[Applies to plan designs that include mail order.]

[Prescription Drug Products from a Mail Order Network Pharmacy]

[Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on mail order Network Pharmacy supply limits.

Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.]

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* apply also to this Rider, except that any preexisting condition exclusion in the *Certificate* is not applicable to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

[Variable exclusions below are plan design-specific.]

1. Brand-name Prescription Drug Products which are not otherwise specifically stated in this Rider as covered.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- [4.] [\[Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.\]](#)
- [5.] Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- [6.] Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion will not apply to Prescription Drug Products approved by the *United States Food and Drug Administration (USFDA)* for use in the treatment of cancer on the basis that the Prescription Drug Product has not been approved by the *USFDA* for the treatment of the specific type of cancer for which the Prescription Drug Product has been prescribed, provided:
 - the Prescription Drug Product has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one or more compendia:
 - ◆ *the American Hospital Formulary Service Drug Information;*
 - ◆ *the United States Pharmacopoeia Dispensing Information;* or
 - the Prescription Drug Product has been recognized as safe and effective for treatment of that specific type of cancer in two articles from medical literature that have not had their recognition of the Prescription Drug Product's safety and effectiveness contraindicated by clear and convincing evidence in another article from medical literature.

Medical literature is defined as articles from major peer reviewed medical journals specified by the *United States Department of Health and Human Services*.
- [7.] Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- [8.] Prescription Drug Products for any condition, Injury, Sickness or [\[mental illness\]](#) [\[Mental Illness\]](#) arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- [9.] [\[Any product dispensed for the purpose of appetite suppression or weight loss.\]](#)

¹Remove for religious employers who choose to exclude contraceptive coverage. ²Include when immunizations administered in a pharmacy are covered under the Outpatient Pharmacy Rider. Select appropriate pharmacy or combination of pharmacies where coverage is provided.

- [10.] A Pharmaceutical Product for which Benefits are provided in your *Certificate of Coverage*. [¹This exclusion does not apply to covered injectable drugs used for contraception.] [²This exclusion does not apply to immunizations administered in a [Network] [,] [non-Network] [Network or non-Network] [or] [a Designated] Pharmacy.]
- [11.] Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- [12.] General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- [13.] Unit dose packaging of Prescription Drug Products.
- [14.] Medications used for cosmetic purposes.
- [15.] Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
- [16.] Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

¹Include for religious employers who choose to exclude contraceptive coverage.

[¹[18.] Prescription Drug Products when prescribed to prevent conception, including, but not limited to, oral contraceptives, diaphragms, and injectable drugs used for contraception.]

[19.] [Treatment for toenail Onychomycosis (toenail fungus).]

[¹Include for groups that purchase benefits for only certain smoking cessation products.]

[20.] [[¹Certain] Prescription Drug Products for smoking cessation.]

[Applies when plan design includes a closed benefit.]

[21.] [Prescription Drug Products not included on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] of the Prescription Drug List at the time the Prescription Order or Refill is dispensed.]

[Applies when plan design includes closed-panel.]

[22.] [A Prescription Drug Product prescribed by a non-Network Physician or other non-Network provider.]

[23.] Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.

[¹Include when a prescription order/refill is required for coverage. ²Include if group purchases benefits for smoking cessation that includes over-the-counter drugs.]

[24.] [Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product [¹and it is obtained with a Prescription Order or Refill from a Physician]. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. [²This exclusion does not apply to over-the-counter drugs used for smoking cessation.]]

[25.] [Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.]

- [26.] Growth hormone therapy.
- [27.] [Any oral non-sedating antihistamine or antihistamine-decongestant combination.]
- [28.] [Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.]
- [29.] Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, **except that Medical Foods and Low Protein Modified Food Products are covered, as described in Section 1: Covered Health Services of the Certificate, for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias and disorders of amino acid metabolism if the products are prescribed and administered under the direction of a Physician.**
- [30.] [A particular Therapeutic Class or Therapeutic Classes. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Therapeutic Class or Therapeutic Classes are excluded.]
- [31.] [Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.]
- [32.] [Prescription Drug Products when prescribed as sleep aids.]
- [33.] [A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.]
- [34.] [A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.]
- [35.] Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

Section 3: Defined Terms

[Variable definitions below are plan design-specific.]

[Annual Drug Deductible - the amount you are required to pay for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4]] Prescription Drug Products in a year before we begin paying for Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Drug Deductible applies.]

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

[Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products[, including, but not limited to, Specialty Prescription Drug Products]. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.]

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

[¹Include when plan design includes specialty prescription drug program.]

[List of Preventive Medications - a list that identifies certain Prescription Drug Products [¹, which may include certain Specialty Prescription Drug Products,] on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may obtain the List of Preventive Medications through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Maximum Allowable Amount - the maximum amount that should be paid for covered Prescription Drug Products in a Therapeutic Class. This amount is subject to our periodic review and modification and varies by Therapeutic Class.]

[Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our periodic review and modification.]

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our Prescription Drug List (PDL) Management Committee.
- December 31st of the following calendar year.

[Non-Preferred Retail Mail Order Pharmacy - a mail order pharmacy that we identify as a non-preferred pharmacy within the Network.]

[Non-Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a non-preferred pharmacy within the Network.]

[Out-of-Pocket Drug Maximum - the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Out-of-Pocket Drug Maximum applies.]

Predominant Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. We calculate the Predominant Reimbursement Rate using our Prescription Drug Charge that applies for that particular Prescription Drug Product at most Network Pharmacies.

[Preferred Mail Order Network Pharmacy - a mail order pharmacy that we identify as a preferred pharmacy within the Network.]

[Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network.]

[Applies when plan design includes mail order and MAC pricing.]]¹ Applies when plan design includes coverage for any brand-name drug.]

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy. [The Prescription Drug Charge for a Generic Prescription Drug Product dispensed by a mail order Network Pharmacy, however, will be the Maximum Allowable Cost (MAC) List price which may be higher or lower than the rate we have agreed to pay the mail order Network Pharmacy. We establish the Maximum Allowable Cost (MAC) List price. You may access the amount you will pay for a [¹Brand-name or] Generic Prescription Drug Product to be dispensed by a retail Network Pharmacy and/or a mail order Network Pharmacy through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Depending upon your plan design, the amount you will pay may be a Copayment, Coinsurance or the Prescription Drug Charge.]

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- [Inhalers (with spacers).]
- Oral diabetic agents.
- Insulin.

¹Include when corresponding exception for immunizations administered in a pharmacy is included in exclusion #8

- [¹Immunizations administered in a pharmacy.]
- The following diabetic supplies:
 - standard insulin syringes with needles;

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- blood-testing strips - glucose;
- urine-testing strips - glucose;
- ketone-testing strips and tablets;
- lancets and lancet devices; and
- glucose monitors.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

[Preventive Care Medications – the medications that are obtained at a Network Pharmacy [with a Prescription Order or Refill from a Physician] and that are payable at 100% of [the Prescription Drug Cost] [the cost] (without application of any Copayment, Coinsurance, Annual Deductible or Annual Drug Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.

[Applies if immunizations are covered under the pharmacy benefit:]

- [Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.]
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.]

You may determine whether a drug is a Preventive Care Medication through the internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. [Specialty Prescription Drug Products may include drugs on the List of Preventive Medications.] You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Specialty Prescription Drug Product Out-of-Pocket Maximum - the maximum amount you are required to pay for covered Specialty Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Specialty Prescription Drug Product Out-of-Pocket Maximum applies.]

[Therapeutic Class - a group or category of Prescription Drug Products with similar uses and/or actions.]

[Therapeutic Class Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product that is dispensed at your or your provider's request is in a Therapeutic Class where we have determined a Maximum Allowable Amount. For Prescription Drug Products from Network Pharmacies, the Therapeutic Class Charge is calculated as the difference between the Prescription Drug Charge for Network Pharmacies for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutic Class. For Prescription Drug Products from non-Network Pharmacies, the Therapeutic Class Charge is calculated as the difference between the Predominant Reimbursement Rate for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutic Class.]

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

[Therapeutically Equivalent Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product that is dispensed at your or your

provider's request is Therapeutically Equivalent to a Prescription Drug Product where we have determined a Maximum Allowable Amount. For Prescription Drug Products from Network Pharmacies, the Therapeutically Equivalent Charge is calculated as the difference between the Prescription Drug Charge for Network Pharmacies for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutically Equivalent Prescription Drug Product. For Prescription Drug Products from non-Network Pharmacies, the Therapeutically Equivalent Charge is calculated as the difference between the Predominant Reimbursement Rate for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutically Equivalent Prescription Drug Product.]

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

[The following bracketed provisions are variable based on plan design throughout this schedule:]

[Copayment provision: Applies when plan design includes a copayment provision. When included the copayment provision may be tiered or not tiered. When included, the annual drug deductible does not apply.]

[Annual drug deductible: Applies when plan design includes an annual drug deductible provision. When included, the copayment provision does not apply.]

[Maximum per drug benefit: Always applies, however it may or may not be a tiered benefit.]

[Per drug out-of-pocket maximum: Applies when plan design includes a per drug out-of-pocket maximum in addition to the standard annual out-of-pocket maximum.]

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to payment requirements as described in this *Schedule of Benefits*.

Contraceptives are mandated in AR, except for religious group employers. ¹Remove for religious employers who choose to exclude contraceptive coverage.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service¹ *or is prescribed to prevent conception*.

If a Brand-name Drug Becomes Available as a Generic

When a Prescription Drug Product becomes available as a Generic, the tier placement of the Brand-name version may change. When this occurs, *[your Copayment may change][and] [the Maximum Per Drug Benefit [(including the Specialty Drug Maximum Per Drug Benefit)] may change]*.

If you choose to receive the Generic drug:

- *[You will pay the Copayment for the tier to which the Generic Prescription Drug Product is assigned.]*
- You will pay the amount that exceeds the Maximum Per Drug Benefit *[or the Specialty Drug Maximum Per Drug Benefit]* for the tier to which the Generic Prescription Drug Product is assigned.
- *[Your payments will be limited by the Per Drug Out-of-Pocket Maximum.]*

If you choose to continue receiving the Brand-name drug or if your Physician determines that you should continue receiving the Brand-name drug:

- *[You will pay the Copayment for the tier to which the Brand -name Prescription Drug Product is assigned.]*
- You will pay the amount that exceeds the Maximum Per Drug Benefit *[or the Specialty Drug Maximum Per Drug Benefit]* for tier to which the Brand-name Prescription Drug Product is assigned.
- *[Your payments will be limited by the Per Drug Out-of-Pocket Maximum.]*

The terms "generic" and "brand-name" are used in the health care industry in many different ways. To be sure that you know whether a drug is classified as Brand-name or Generic by us, please review the definitions contained in *Section 3: Defined Terms* at the end of this Rider. You should also check the current classification on the Prescription Drug List through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. [\[For a single Copayment, you\]](#) [\[You\]](#) may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

[Variable references here and throughout are used to support either notification or prior authorization requirements.]

[Notification] [Prior Authorization] Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to [\[notify\]](#) [\[obtain prior authorization from\]](#) us or our designee. The reason for [\[notifying\]](#) [\[obtaining prior authorization from\]](#) us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to [\[notify\]](#) [\[obtain prior authorization from\]](#) us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy [Notification] [Prior Authorization]

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for [\[notifying\]](#) [\[obtaining prior authorization from\]](#) us.

Non-Network Pharmacy [Notification] [Prior Authorization]

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for [\[notifying\]](#) [\[obtaining prior authorization from\]](#) us as required.

If [\[we are not notified\]](#) [\[you do not obtain prior authorization from us\]](#) before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring [\[notification\]](#) [\[prior authorization\]](#) are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires [\[notification\]](#) [\[prior authorization\]](#) through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

If [\[we are not notified\]](#) [\[you do not obtain prior authorization from us\]](#) before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not [\[notify\]](#) [\[obtain prior authorization from\]](#) us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less [\[the required \[Copayment\] \[Annual Drug Deductible\] and\]](#) any amount that exceeds the Maximum Per Drug Benefit [\[or the Specialty Drug Maximum Per Drug Benefit\]](#). The amount that you must pay is limited by [\[the Per Drug Out-of-Pocket Maximum and\]](#) the Annual Out-of-Pocket Drug Maximum.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require [\[notification\]](#) [\[prior authorization\]](#) for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable [\[notification\]](#) [\[prior authorization\]](#), participation or activation requirements associated with such programs through the Internet at [\[www.myuhc.com\]](#) or by calling *Customer Care* at the telephone number on your ID card.

[Step Therapy]

[\[Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products for which Benefits are described in your *Certificate* are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product\(s\) or Pharmaceutical Product\(s\) first.\]](#)

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at [\[www.myuhc.com\]](#) or by calling *Customer Care* at the telephone number on your ID card.]

What You Must Pay

[\[The following bracketed provisions are plan design variable.\]](#)

[\[You are responsible for paying the applicable Copayment described in the *Benefit Information* table when Prescription Drug Products are obtained from a pharmacy.\]](#)

[\[After you pay the applicable Copayment, we will pay a Maximum Per Drug Benefit \[or a Specialty Drug Maximum Per Drug Benefit\] for the Prescription Drug Product. \[The Maximum Per Drug Benefit is described in the *Benefit Information* table.\] \[The Maximum Per Drug Benefit and the Specialty Drug Maximum Per Drug Benefit are described in the *Benefit Information* table.\]](#)

[\[Benefits for Preventive Care Medications are not subject to a Maximum Per Drug Benefit \[,\] \[or\] \[a Specialty Drug Maximum Per Drug Benefit\] or to payment of the Copayment.\]](#)

[\[You are responsible for paying the Annual Drug Deductible described in the *Payment Information* table when Prescription Drug Products are obtained from a pharmacy.\]](#)

[\[After you pay the Annual Drug Deductible, we will pay a Maximum Per Drug Benefit \[or a Specialty Drug Maximum Per Drug Benefit\] for the Prescription Drug Product. \[The Maximum Per Drug Benefit is described in the *Benefit Information* table.\] \[The Maximum Per Drug Benefit and the Specialty Drug Maximum Per Drug Benefit are described in the *Benefit Information* table.\]](#)

[\[Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.\]](#)

[\[Benefits for Preventive Care Medications are not subject to a Maximum Per Drug Benefit \[,\] \[or\] \[a Specialty Drug Maximum Per Drug Benefit\] or to payment of the Annual Drug Deductible.\]](#)

[\[Benefits for \[insulin\] \[or\] \[diabetic supplies\] are not subject to payment of the Annual Drug Deductible.\]](#)

[You are responsible for paying the Annual Deductible stated in the *Schedule of Benefits* which is attached to your *Certificate* before Benefits for Prescription Drug Products under this Rider are available to you.]

[Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Deductible.]

[Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.]

[Benefits for [insulin] [or] [diabetic supplies] are not subject to payment of the Annual Deductible.]

After we pay the Maximum Per Drug Benefit [or Specialty Drug Maximum Per Drug Benefit], you are responsible for paying any amount that exceeds the Maximum Per Drug Benefit [or Specialty Drug Maximum Per Drug Benefit]. The amount you pay will be limited by [a Per Drug Out-of-Pocket Maximum, and will be further limited by] an Annual Out-of-Pocket Drug Maximum. See the *Payment Information* table for a description of the [Per Drug Out-of-Pocket Maximum and the] Annual Out-of-Pocket Drug Maximum. [Benefits for Preventive Care Medications are not subject to a Maximum Per Drug Benefit [or a Specialty Drug Maximum Per Drug Benefit].]

Any amount you pay for Prescription Drug Products under this Rider, including any amount you pay for a non-covered drug product or any amount you pay for the difference between the Predominant Reimbursement Rate and a non-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product, will not be included in calculating any Out-of-Pocket Maximum stated in your *Certificate*. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

[The Annual Drug Deductible is calculated on a [calendar] [Policy] year basis.]

The Annual Out-of-Pocket Drug Maximum is calculated on a [calendar] [Policy] year basis.

Payment Term And Description	Amounts
<p>[Annual Drug Deductible]</p>	
<p><i>[Annual drug deductible is plan design variable and when included, the copayment provision cannot apply.]</i></p> <p>[The amount you pay for covered Prescription Drug Products in a year before we begin paying for Prescription Drug Products.]</p> <p>[Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.]</p> <p>[Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.]</p> <p>[Benefits for [insulin] [or] [diabetic supplies] are not subject to payment of the Annual Drug Deductible.]</p> <p><i>[¹Applies when only the individual portion is subject to the annual drug deductible.]</i></p> <p>[Any amount you pay that is applied to the Annual Drug Deductible in the last quarter of the previous [calendar] [Policy] year will be carried over and applied to the current Annual Drug Deductible. [¹This carry-over feature applies only to the individual Annual Drug Deductible.]]</p> <p>[When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual drug deductible provision of the prior policy will apply to the Annual Drug Deductible provision under the Policy.]</p> <p><i>[Applies when the roll-over provision applies to a group changing from a calendar year to policy year plan. ¹Applies when only the individual portion is subject to the annual drug deductible.]</i></p> <p>[When the Enrolling Group changes</p>	<p>[\$[100 - 1,000] per Covered Person.]</p> <p>[\$[100 - 1,000] per Covered Person, not to exceed \$[300 - 3,000] for all Covered Persons in a family.]</p>

Payment Term And Description	Amounts
<p>from a calendar year to a Policy year plan, any amount you pay for Prescription Drug Product expenses in the last three months of the previous calendar year that is applied to the previous Annual Drug Deductible, will be rolled over and applied to the current Policy year Annual Drug Deductible. This roll-over feature applies only to the first Policy year. [¹This roll-over feature applies only to the individual Annual Drug Deductible.]</p> <p>[Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>	
<p>Annual Out-of-Pocket Drug Maximum</p>	
<p><i>[The following bracketed provision are plan design variable.]</i></p> <p>The maximum amount you are required to pay for covered Prescription Drug Products in a year. Once you reach the Annual Out-of-Pocket Drug Maximum, you will not be required to pay [Copayments or] the amount that exceeds the Maximum Per Drug Benefit [or the Specialty Drug Maximum Per Drug Benefit] for covered Prescription Drug Products for the remainder of the year. [The Annual Out-of-Pocket Drug Maximum includes the Copayment.] [The Annual Out-of-Pocket Drug Maximum includes the Annual Drug Deductible.]</p>	<p>[\$500 - 15,000] per Covered Person.]</p> <p>[\$500 - 15,000] per Covered Person, not to exceed \$[1,250 - 75,000] for all Covered Persons in a family.]</p>
<p>[Copayment]</p>	
<p><i>[Copayment is plan design variable and may only be included when the annual drug deductible provision does not apply.]</i></p> <p>[The Copayment for a Prescription Drug Product at a Network or non-Network Pharmacy is a specific dollar amount. Your Copayment is determined by the</p>	<p><i>[¹Applies when our negotiated rate does not apply.]</i></p> <p><i>[²Applies when our negotiated rate applies.]</i></p> <p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the [¹lower] [²lowest] of the following:</p> <ul style="list-style-type: none"> • The applicable Copayment. • The Network Pharmacy's Usual and Customary Charge for the

Payment Term And Description	Amounts
<p>tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product.]</p> <p>[Your Copayment may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable [notification] [prior authorization] participation or activation requirements associated with such programs through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p> <p>[Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>[Prescription Drug Products Prescribed by a Specialist Physician: You may receive a reduced or increased Copayment based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p> <p>[NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier</p>	<p>Prescription Drug Product.</p> <ul style="list-style-type: none"> • ²The Prescription Drug Charge for that Prescription Drug Product.] <p>[For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> • The applicable Copayment. • The Prescription Drug Charge for that Prescription Drug Product.] <p>[See the Copayments stated in the <i>Benefit Information</i> table for amounts.]</p> <p>[You are not responsible for paying a Copayment for Preventive Care Medications.]</p>

Payment Term And Description	Amounts
<p>assignment. Please access [www.myuhc.com] through the Internet or call <i>Customer Care</i> at the telephone number on your ID card for the most up-to-date tier status.]</p> <p>[Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com] or by calling <i>Customer Care</i> at the telephone number on your ID card.]</p>	
<p>Maximum Per Drug Benefit</p>	
<p><i>[The following bracketed provision are plan design variable.]</i></p> <p>The maximum amount we will pay [after you have paid [the Annual Drug Deductible] [the applicable Copayment] for any covered Prescription Order or Refill before you reach the [Per Drug Out-of-Pocket Maximum or the] Annual Out-of-Pocket Drug Maximum.</p> <p><i>[Applies to plan designs that include a tiered maximum per drug benefit.]</i></p> <p>[The Maximum per Drug Benefit is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product.]</p> <p><i>[Applies to plan designs that include a tiered maximum per drug benefit.]</i></p> <p>[NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call <i>Customer Care</i> at the telephone number on your ID card for the most up-to-date tier status.]</p>	<p><i>[¹Applies when our negotiated rate does not apply.]</i></p> <p><i>[²Applies when our negotiated rate applies.]</i></p> <p>For Prescription Drug Products at a retail Network Pharmacy, the Maximum Per Drug Benefit is [¹lower] [²lowest] of:</p> <ul style="list-style-type: none"> • The applicable Maximum Per Drug Benefit. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • [²The Prescription Drug Charge for that Prescription Drug Product.] <p>For Prescription Drug Products at a retail non-Network Pharmacy, the Maximum Per Drug Benefit is the lower of:</p> <ul style="list-style-type: none"> • The applicable Maximum Per Drug Benefit. • The non-Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. <p><i>[Include when mail order pharmacy is sold.]</i></p> <p>[For Prescription Drug Products at a mail service Network Pharmacy, the Maximum Per Drug Benefit is the lower of:</p> <ul style="list-style-type: none"> • The applicable Maximum Per Drug Benefit. • The Prescription Drug Charge for that Prescription Drug Product.] <p>See the Maximum Per Drug Benefit stated in the <i>Benefit Information</i> table for amounts.</p> <p>[The Maximum Per Drug Benefit does not apply to Preventive Care Medications.]</p>

Payment Term And Description	Amounts
<p>[Specialty Drug Maximum Per Drug Benefit]</p> <p><i>[Specialty drug maximum per drug benefit is plan design variable.]</i></p> <p>[The maximum amount we will pay [after you have paid [the Annual Drug Deductible] [the applicable Copayment] for Prescription Order or Refill for a covered Specialty Prescription Drug Product before you reach the [Per Drug Out-of-Pocket Maximum or the] Annual Out-of-Pocket Drug Maximum.</p> <p><i>[Applies to plan designs that include a tiered specialty drug maximum per drug benefit.]</i></p> <p>[The Specialty Drug Maximum per Drug Benefit is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product.]</p> <p><i>[Applies to plan designs that include a tiered specialty drug maximum per drug benefit.]</i></p> <p>[NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call <i>Customer Care</i> at the telephone number on your ID card for the most up-to-date tier status.]]</p>	<p><i>[¹Applies when our negotiated rate does not apply.]</i></p> <p><i>[²Applies when our negotiated rate applies.]</i></p> <p>[For Specialty Prescription Drug Products at a retail Network Pharmacy, the Specialty Drug Maximum Per Drug Benefit is [¹lower] [²lowest] of:</p> <ul style="list-style-type: none"> • The applicable Specialty Drug Maximum Per Drug Benefit, or • The Network Pharmacy's Usual and Customary Charge for the Specialty Prescription Drug Product. • [²The Prescription Drug Charge for that Specialty Prescription Drug Product.] <p>For Prescription Drug Products at a retail non-Network Pharmacy, the Specialty Drug Maximum Per Drug Benefit is the lower of:</p> <ul style="list-style-type: none"> • The applicable Specialty Drug Maximum Per Drug Benefit, or • The non-Network Pharmacy's Usual and Customary Charge for the Specialty Prescription Drug Product. <p>[For Specialty Prescription Drug Products at a mail service Network Pharmacy, the Specialty Drug Maximum Per Drug Benefit is the lower of:</p> <ul style="list-style-type: none"> • The applicable Specialty Drug Maximum Per Drug Benefit. • The Prescription Drug Charge for that Specialty Prescription Drug Product.] <p>See the Specialty Drug Maximum Per Drug Benefit stated in the <i>Benefit Information</i> table for amounts.]</p> <p>[The Specialty Drug Maximum Per Drug Benefit does not apply to Preventive Care Medications.]</p>
<p>[Per Drug Out-of-Pocket Maximum]</p>	
<p><i>[Per drug out-of-pocket maximum provision is plan design variable. ¹Applies when plan design includes a specialty drug maximum per drug benefit.]</i></p> <p>[The maximum amount you are required to pay for a Prescription Order or Refill. Once you reach the Per Drug Out-of-Pocket Maximum for a Prescription</p>	<p><i>[Per drug out-of-pocket maximum is plan design variable. Plan may include a per drug out-of-pocket maximum by tier or without tiers. Plan may include a separate per drug out-of-pocket maximum for drugs on the list of preventive medications.]</i></p> <p>[For up to a 31-day supply, the Per Drug Out-of-Pocket Maximum is:]</p> <p>[\$[0-350] per Prescription Order or Refill [for a Tier 1 Prescription Drug Product].]</p> <p>[\$[200-1,000] per Prescription Order or Refill for a Tier 2 Prescription</p>

Payment Term And Description	Amounts
<p>Order or Refill, you will not be required to pay any amount that exceeds the Maximum Per Drug Benefit [¹or the Specialty Drug Maximum Per Drug Benefit]. The amount you are required to pay after we have paid the Maximum Per Drug Benefit [¹or the Specialty Drug Maximum Per Drug Benefit], before you reach the Per Drug Out-of-Pocket Maximum, is based on the following:</p> <ul style="list-style-type: none"> • For Prescription Drug Products from a Network Pharmacy, your payment is based on the Prescription Drug Charge. • For Prescription Drug Products from a non-Network Pharmacy, your payment is based on the Predominant Reimbursement Rate.] <p>[NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access [www.myuhc.com] through the Internet or call <i>Customer Care</i> at the telephone number on your ID card for the most up-to-date tier status.]</p>	<p>Drug Product.]</p> <p>[\$[350-2,000] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.]</p> <p>[\$[500-5,000] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.]</p> <p>[\$[0-5,000] per Prescription Order or Refill for a Prescription Drug Product on the List of Preventive Medications.]</p> <p><i>[Apply the 62 and 90-day supply per drug out-of-pocket maximum when plan design applies the mail order provision or if benefits for maintenance medications are included.]</i></p> <p>[For a 32-day to a 62-day supply, the Per Drug Out-of-Pocket Maximum is:]</p> <p>[\$[0-700] per Prescription Order or Refill [for a Tier 1 Prescription Drug Product].]</p> <p>[\$[400-2,000] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.]</p> <p>[\$[700-4,000] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.]</p> <p>[\$[1,000-10,000] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.]</p> <p>[\$[0-10,000] per Prescription Order or Refill for a Prescription Drug Product on the List of Preventive Medications.]</p> <p>[For a 63-day to a 90-day supply, the Per Drug Out-of-Pocket Maximum is:]</p> <p>[\$[0-1,050] per Prescription Order or Refill [for a Tier 1 Prescription Drug Product].]</p> <p>[\$[500-3,000] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.]</p> <p>[\$[875-6,000] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.]</p> <p>[\$[1,250-15,000] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.]</p> <p>[\$[0-15,000] per Prescription Order or Refill for a Prescription Drug Product on the List of Preventive Medications.]</p> <p><i>[Applies when plan design includes the copayment provision.]</i></p> <p>[The Per Drug Out-of-Pocket Maximum includes the Copayment.]</p>

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
<p>[Specialty Prescription Drug Products]</p>	
<p><i>[Specialty prescription drug products is a plan design variable.]</i></p> <p>[The following supply limits apply.]</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive [31] [60]-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. <p>When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive [31]-day supply, the Copayment that applies will reflect the number of days dispensed.</p> <p>Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy [,] [or] a non-Network Pharmacy [,] [or] [a mail order Network Pharmacy] [or] [a Designated Pharmacy].</p>	<p><i>[Applies when plan design includes the copayment provision. When included, the annual drug deductible provision below will not apply.]</i></p> <p><i>[Variable provisions allow for tier structure to either apply or not apply based on plan design. Variables allow for differing copayments for growth hormone therapy and drugs on the list of preventive medications.]</i></p> <p><i>[For up to a [31] [60]-day supply, you must pay your Copayment:]</i></p> <p>[Your Copayment is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4]. Please access [www.myuhc.com] through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.]</p> <p><i>[Network Pharmacy]</i></p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[0-100] per Prescription Order or Refill [,] except that we pay 100% of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy after you pay a Copayment of \$[0-200]].]</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[0-100] per Prescription Order or Refill] for a Specialty Prescription Drug Product on the List of Preventive Medications.]</p> <p>[For a Tier 1 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$[0-35] per Prescription Order or Refill [,] except that we pay 100% of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy after you pay a Copayment of \$[0-50]].]</p> <p>[For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: 100% of the Prescription Drug Charge [after you pay a Copayment of \$[0-35] per Prescription Order or Refill].]</p> <p>[For a Tier 2 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$[25-90] per Prescription Order or Refill [,] except that we pay 100% of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy after you pay a Copayment of \$[45-120]].]</p> <p>[For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: 100% of the Prescription Drug Charge [after you pay a Copayment of \$[25-90] per Prescription Order or Refill].]</p> <p>[For a Tier 3 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$[45-90] per Prescription Order or Refill [,] except that we pay 100% of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>hormone therapy after you pay a Copayment of \$[60-150]].]</p> <p>[For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: 100% of the Prescription Drug Charge [after you pay a Copayment of \$[45-90] per Prescription Order or Refill].]</p> <p>[For a Tier 4 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$[50-100] per Prescription Order or Refill [, except that we pay 100% of the Prescription Drug Charge for a Specialty Prescription Drug Product for growth hormone therapy after you pay a Copayment of \$[65-200]].]</p> <p>[For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: 100% of the Prescription Drug Charge [after you pay a Copayment of \$[50-100] per Prescription Order or Refill].]</p> <p>[Non-Network Pharmacy]</p> <p>[100% of the Predominant Reimbursement Rate after you pay a Copayment of \$[0-100] per Prescription Order or Refill [, except that we pay 100% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy after you pay a Copayment of \$[0-200]].]</p> <p>[100% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-100] per Prescription Order or Refill] for a Specialty Prescription Drug Product on the List of Preventive Medications.]</p> <p>[For a Tier 1 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$[0-35] per Prescription Order or Refill [, except that we pay 100% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy after you pay a Copayment of \$[0-50]].]</p> <p>[For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: 100% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[0-35] per Prescription Order or Refill].]</p> <p>[For a Tier 2 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$[25-90] per Prescription Order or Refill [, except that we pay 100% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy after you pay a Copayment of \$[45-120]].]</p> <p>[For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: 100% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[25-90] per Prescription Order or Refill].]</p> <p>[For a Tier 3 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$[45-90] per Prescription Order or Refill [, except that we pay 100% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy after you pay a Copayment of \$[60-150]].]</p> <p>[For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: 100% of the Predominant Reimbursement Rate</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>[after you pay a Copayment of \$[45-90] per Prescription Order or Refill].]</p> <p>[For a Tier 4 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$[50-100] per Prescription Order or Refill [, except that we pay 100% of the Predominant Reimbursement Rate for a Specialty Prescription Drug Product for growth hormone therapy after you pay a Copayment of \$[65-200]].]</p> <p>[For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: 100% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[50-100] per Prescription Order or Refill].]</p> <p><i>[Applies when the plan design includes an annual drug deductible option. When included, the copayment provision above does not apply.]</i></p> <p><i>[You must pay the Annual Drug Deductible. Once you have paid the Annual Drug Deductible, we will pay 100% of the Prescription Drug Charge or the Predominant Reimbursement Rate until the Maximum Per Drug Benefit is reached.]</i></p> <p><i>[¹ Does not apply when plan design does not apply either the copayment provision or the annual drug deductible provision.]</i></p> <p><i>[Variable provisions allow for tier structure to either apply or not apply based on plan design. Variables allow for differing maximum drug benefit for drugs on the list of preventive medications.]</i></p> <p><i>[You must ¹ also] pay any amount that exceeds the Maximum Per Drug Benefit.]</i></p> <p>[For up to a 31-day supply, the Maximum Per Drug Benefit is:]</p> <p>[\$[0-250] per Prescription Order or Refill [for a Tier 1 Specialty Prescription Drug Product].]</p> <p>[\$[0-250] per Prescription Order or Refill for a [Tier 1] Specialty Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[10-250] per Prescription Order or Refill for a Tier 2 Specialty Prescription Drug Product.]</p> <p>[\$[10-250] per Prescription Order or Refill for a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[15-2,500] per Prescription Order or Refill for a Tier 3 Specialty Prescription Drug Product.]</p> <p>[\$[15-2,500] per Prescription Order or Refill for a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[20-3,000] per Prescription Order or Refill for a Tier 4 Specialty Prescription Drug Product.]</p> <p>[\$[20-3,000] per Prescription Order or Refill for a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications.]</p>
<p>Prescription Drugs from a Retail Network Pharmacy</p>	

Description and Supply Limits	Benefit (The Amount We Pay)
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. <p><i>Include for groups that purchase the mail order benefit</i></p> <ul style="list-style-type: none"> [If the Network Pharmacy agrees to provide the same services or products for the same terms as the mail order Network Pharmacy, you may obtain up to a consecutive 90-day supply of a Prescription Drug Product.] <p><i>Contraceptives are mandated in AR, except for religious group employers. ¹Remove for religious employers who choose to exclude contraceptive coverage. ²Include if the Copayment option applies to this benefit design.</i></p> <ul style="list-style-type: none"> [¹A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time [²if you pay a Copayment for each cycle supplied]. When you obtain up to three cycles at one time, we will pay up to three times the Maximum Per Drug Benefit.] 	<p><i>[Applies when plan design includes the copayment provision. When included, the annual drug deductible provision below will not apply.</i></p> <p><i>Variable provisions allow for tier structure to either apply or not apply based on plan design. Variables allow for differing copayments for drugs on the list of preventive medications.]</i></p> <p>[Your Copayment is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4]. Please access [www.myuhc.com] through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.]</p> <p>[For up to a 31-day supply, you must pay your Copayment:]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[0-90] per Prescription Order or Refill [for a Tier 1 Prescription Drug Product].</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[0-90]] per Prescription Order or Refill for a [Tier 1] Prescription Drug Product on the List of Preventive Medications.]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[25-75] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.]</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[25-75]] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[45-85] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.]</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[45-85]] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[50-90] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.]</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[50-90]] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.]</p> <p><i>[Include when 90 day generic coverage applies.]</i></p> <p>[For a 90-day supply of a Generic for which the Usual and Customary Charge does not exceed \$[10 - 20], we pay:]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[0-20] per Prescription Order or Refill [for a Tier 1 Prescription Drug Product].</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill for a [Tier 1] Prescription Drug</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>Product on the List of Preventive Medications.]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[0-20] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.]</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[0-20] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.]</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[0-20] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.]</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[0-20]] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.]</p> <p><i>[Applies when the plan design includes an annual drug deductible option. When included, the copayment provision above does not apply.]</i></p> <p><i>[You must pay the Annual Drug Deductible. Once you have paid the Annual Drug Deductible, we will pay 100% of the Prescription Drug Charge until the Maximum Per Drug Benefit is reached.]</i></p> <p><i>[¹ Does not apply when plan design does not apply either the copayment provision or the annual drug deductible provision.]</i></p> <p><i>[Variable provisions allow for tier structure to either apply or not apply based on plan design. Variables allow for differing maximum drug benefit for drugs on the list of preventive medications.]</i></p> <p><i>[You must ¹ also pay any amount that exceeds the Maximum Per Drug Benefit.]</i></p> <p>[For up to a 31-day supply, the Maximum Per Drug Benefit is:]</p> <p>\$[0-250] per Prescription Order or Refill [for a Tier 1 Prescription Drug Product].</p> <p>[\$[0-250] per Prescription Order or Refill for a [Tier 1] Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[10-250] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.]</p> <p>[\$[10-250] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[15-2,500] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.]</p> <p>[\$[15-2,500] per Prescription Order or Refill for a Tier 3 Prescription Drug</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>Product on the List of Preventive Medications.]</p> <p>[\$[20-3,000] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.]</p> <p>[\$[20-3,000] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.]</p> <p><i>[Include when 90 day generic coverage applies.]</i></p> <p>[For a 90-day supply of a Generic for which the Usual and Customary Charge does not exceed \$[10 - 20], the Maximum Per Drug Benefit is:]</p> <p>[\$[0-20] per Prescription Order or Refill [for a Tier 1 Prescription Drug Product].</p> <p>[\$[0-20] per Prescription Order or Refill for a [Tier 1] Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[0-20] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.]</p> <p>[\$[0-20] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[0-20] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.]</p> <p>[\$[0-20] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[0-20] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.]</p> <p>[\$[0-20] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.]</p>
<p>Prescription Drugs from a Retail Non-Network Pharmacy</p>	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. <p><i>Contraceptives are mandated in AR, except for religious group employers.¹ Remove for religious employers who choose to exclude contraceptive coverage.² Include if the Copayment option applies to this benefit design.</i></p> <ul style="list-style-type: none"> ¹A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time ²if you 	<p><i>[Applies when plan design includes the copayment provision. When included, the annual drug deductible provision below will not apply.]</i></p> <p><i>[Variable provisions allow for tier structure to either apply or not apply based on plan design. Variables allow for differing copayments for drugs on the list of preventive medications.]</i></p> <p>[Your Copayment is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4]. Please access [www.myuhc.com] through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.]</p> <p><i>[For up to a 31-day supply, you must pay your Copayment:]</i></p> <p>[100% of the Predominant Reimbursement Rate after you pay a Copayment of \$[0-90] per Prescription Order or Refill [for a Tier 1 Prescription Drug Product].]</p> <p>[100% of the Predominant Reimbursement Rate [after you pay a</p>

Description and Supply Limits	Benefit (The Amount We Pay)
<p>pay a Copayment for each cycle supplied]. When you obtain up to three cycles at one time, we will pay up to three times the Maximum Per Drug Benefit.]</p> <p>[When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment that applies will reflect the number of days dispensed.]</p>	<p>Copayment of \$[0-90]] per Prescription Order or Refill for a [Tier 1] Prescription Drug Product on the List of Preventive Medications.]</p> <p>[100% of the Predominant Reimbursement Rate after you pay a Copayment of \$[25-75] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.]</p> <p>[100% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[25-75] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[100% of the Predominant Reimbursement Rate after you pay a Copayment of \$[45-85] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.]</p> <p>[100% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[45-85]] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[100% of the Predominant Reimbursement Rate after you pay a Copayment of \$[50-90] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.]</p> <p>[100% of the Predominant Reimbursement Rate [after you pay a Copayment of \$[50-90]] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.]</p> <p><i>[Applies when the plan design includes an annual drug deductible option. When included, the copayment provision above does not apply.]</i></p> <p><i>[You must pay the Annual Drug Deductible. Once you have paid the Annual Drug Deductible, we will pay 100% of the Predominant Reimbursement Rate until the Maximum Per Drug Benefit is reached.]</i></p> <p><i>[¹ Does not apply when plan design does not apply either the copayment provision or the annul drug deductible provision.]</i></p> <p><i>[Variable provisions allow for tier structure to either apply or not apply based on plan design. Variables allow for differing maximum drug benefit for drugs on the list of preventive medications.]</i></p> <p><i>[You must [¹ also] pay any amount that exceeds the Maximum Per Drug Benefit.]</i></p> <p>[For up to a 31-day supply, the Maximum Per Drug Benefit is:]</p> <p>[\$[0-250] per Prescription Order or Refill [for a Tier 1 Prescription Drug Product].]</p> <p>[\$[0-250] per Prescription Order or Refill for a [Tier 1] Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[10-250] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.]</p> <p>[\$[10-250] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[15-2,500] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.]</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>[\$[15-2,500] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[20-3,000] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.]</p> <p>[\$[20-3,000] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.]</p>
<p><i>[Applies when plan design includes a mail order benefit]</i></p> <p>[Prescription Drug Products from a Mail Order Network Pharmacy]</p>	
<p>[The following supply limits apply:</p> <p><i>[¹ Applies when plan design includes specialty drug program.]</i></p> <p><i>[² Applies when plan design includes the list of preventive medications.]</i></p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. [¹These supply limits do not apply to Specialty Prescription Drug Products², including Specialty Prescription Drug Products on the List of Preventive Medications]. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading <i>Specialty Prescription Drug Products.</i> <p><i>[Applies if coverage is initially required at a retail pharmacy prior to using mail order.]</i></p> <p>[You may be required to fill an initial Prescription Drug Product order and obtain [1 - 3] refill[s] through a retail pharmacy prior to using a mail order Network Pharmacy.]</p> <p><i>[Applies when initial mail day supply is limited.]</i></p> <p>[You may be limited to a 31-day supply for your initial fill and [1 - 3] refill[s] of certain Prescription Drug Products you obtain through a mail order Network</p>	<p><i>[Applies when plan design includes the copayment provision. When included, the annual drug deductible provision below will not apply.]</i></p> <p><i>[Variable provisions allow for tier structure to either apply or not apply based on plan design. Variables allow for differing copayments for drugs on the list of preventive medications.]</i></p> <p>[Your Copayment is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [,] [or] [Tier 4]. Please access [www.myuhc.com] through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.]</p> <p><i>[You must pay your Copayment:</i></p> <p>[For up to a 31-day supply, your Copayment is:]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[0-90] per Prescription Order or Refill [for a Tier 1 Prescription Drug Product].]</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[0-90]] per Prescription Order or Refill for a [Tier 1] Prescription Drug Product on the List of Preventive Medications.]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[25-75] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.]</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[25-75]] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[45-85] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.]</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[45-85]] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[50-90] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.]</p>

Description and Supply Limits	Benefit (The Amount We Pay)
<p>Pharmacy.]</p> <p><i>[Applies only when mail order copayments in the right hand column are charged for the full 90 day supply. Does not apply when copayments are tied to the 31, 60 and 90 day supply.]</i></p> <p>[To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.]</p>	<p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[50-90]] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[For a 32-day to a 62-day supply, your Copayment is:]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[0-180] per Prescription Order or Refill [for a Tier 1 Prescription Drug Product].]</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[0-180]] per Prescription Order or Refill for a [Tier 1] Prescription Drug Product on the List of Preventive Medications.]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[50-150] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.]</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[50-150]] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[90-170] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.]</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[90-170]] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[100-180] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.]</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[100-180]] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[For a 63-day to a 90-day supply, your Copayment is:]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[0-270] per Prescription Order or Refill [for a Tier 1 Prescription Drug Product].]</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[0-270]] per Prescription Order or Refill for a [Tier 1] Prescription Drug Product on the List of Preventive Medications.]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[62-225] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.]</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[62-225]] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[112-225] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.]</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>[\$[112-255]] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[100% of the Prescription Drug Charge after you pay a Copayment of \$[125-270] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.]</p> <p>[100% of the Prescription Drug Charge [after you pay a Copayment of \$[125-270]] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.]</p> <p><i>[Applies when the plan design includes an annual drug deductible option. When included, the copayment provision above does not apply.]</i></p> <p><i>[You must pay the Annual Drug Deductible. Once you have paid the Annual Drug Deductible, we will pay 100% of the Prescription Drug Charge until the Maximum Per Drug Benefit is reached.]</i></p> <p><i>[¹ Does not apply when plan design does not apply either the copayment provision or the annual drug deductible provision.]</i></p> <p><i>[Variable provisions allow for tier structure to either apply or not apply based on plan design. Variables allow for differing maximum drug benefit for drugs on the list of preventive medications.]</i></p> <p><i>[You must ¹ also] pay any amount that exceeds the Maximum Per Drug Benefit.]</i></p> <p>[For up to a 31-day supply, the Maximum Per Drug Benefit is:]</p> <p>[\$[0-250] per Prescription Order or Refill [for a Tier 1 Prescription Drug Product].]</p> <p>[\$[0-250] per Prescription Order or Refill for a [Tier 1] Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[10-250] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.]</p> <p>[\$[10-250] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[15-2,500] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.]</p> <p>[\$[15-2,500] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[20-3,000] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.]</p> <p>[\$[20-3,000] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[For a 32 day to a 62 day supply, the Maximum Per Drug Benefit is:]</p> <p>[\$[0-500] per Prescription Order or Refill [for a Tier 1 Prescription Drug Product].]</p> <p>[\$[0-500] per Prescription Order or Refill for a [Tier 1] Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[20-500] per Prescription Order or Refill for a Tier 2 Prescription Drug</p>

Description and Supply Limits	Benefit (The Amount We Pay)
	<p>Product.]</p> <p>[\$[20-500] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[30-5,000] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.]</p> <p>[\$[30-5,000] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[40-6,000] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.]</p> <p>[\$[40-6,000] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[For a 63-day to a 90-day supply, the Maximum Per Drug Benefit is:]</p> <p>[\$[0-750] per Prescription Order or Refill [for a Tier 1 Prescription Drug Product].]</p> <p>[\$[0-750] per Prescription Order or Refill for a [Tier 1] Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[25-750] per Prescription Order or Refill for a Tier 2 Prescription Drug Product.]</p> <p>[\$[25-750] per Prescription Order or Refill for a Tier 2 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[37-7,500] per Prescription Order or Refill for a Tier 3 Prescription Drug Product.]</p> <p>[\$[37-7,500] per Prescription Order or Refill for a Tier 3 Prescription Drug Product on the List of Preventive Medications.]</p> <p>[\$[50-9,000] per Prescription Order or Refill for a Tier 4 Prescription Drug Product.]</p> <p>[\$[50-9,000] per Prescription Order or Refill for a Tier 4 Prescription Drug Product on the List of Preventive Medications.]</p>

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms*.

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

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.]

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the *Certificate*.]

[NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* does not apply to Prescription Drug Products covered through this Rider, except that Benefits for Prescription Drug Products will be coordinated with prescription drug benefits provided under Medicare [Part B] [Part D] [Parts B and D].]

(Name and Title)

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or [notification] [prior authorization] requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others, therefore; a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

[¹Applies when plan design includes a copayment provision.]

[²Applies when plan design includes an annual drug deductible provision.]

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge [¹, less the required Copayment] [², after the Annual Drug Deductible has been met].

Submit your claim to:

[Name of Pharmacy Benefit Manager]

[Address of Pharmacy Benefit Manager]

[City, State and Zip Code]

[Applies when plan design includes the designated pharmacy program.]

[¹Applies when plan design includes the specialty drug program.]

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[Designated Pharmacies]

[If you require certain Prescription Drug Products [¹, including, but not limited to, Specialty Prescription Drug Products,] we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Prescription Drug Product.]

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

[Variable provision below supports plan designs that include an annual drug deductible and plan designs that are combined medical/RX plans.]

[¹ Applies when rebates are passed on to customers.]

[² Applies when rebates are not passed on to customers.]

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List [, including those drugs that you purchase prior to meeting the Annual Drug Deductible]. [¹We pass [a portion of] [all of] these rebates on to you and they may be applied to the [Annual Drug Deductible] [or] [combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your *Certificate*] [and] taken into account in determining your Copayments, or may be shared with you at point of service or in another manner.]

[²We do not pass these rebates on to you, nor are they applied to [the Annual Drug Deductible] [or] [combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your *Certificate*] [or] taken into account in determining your Copayments.]

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Rider*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

[Applies when rider is issued with combined medical and pharmacy deductible plans and when incentive programs apply.]

[Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans]

[When you are required to meet a combined medical and pharmacy Annual Deductible before we begin to pay Benefits, as stated in the *Schedule of Benefits* attached to your *Certificate*, we may have certain programs in which you may receive an incentive based on your actions such as selecting a Tier 1 or Tier 2 Prescription Drug Product before you have satisfied your combined Annual Deductible. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

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Section 1: Benefits for Prescription Drug Products

[¹Applies when plan design includes a copayment provision.]

[²Applies when plan design includes an annual drug deductible.]

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to [¹Copayment and other payments] [²Annual Drug Deductible and other payments] that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable [¹Copayment and other payment] [²Annual Drug Deductible and other payment] requirements.

Contraceptives are mandated in AR, except for religious group employers. ¹Remove for religious employers who choose to exclude contraceptive coverage.

¹Include for groups that purchase contraceptive benefits.

²Include for group that purchase closed-panel benefits and the corresponding exclusion is included in Section 2. (Closed panel means that we pay only for drugs that are prescribed by a Network provider.)

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service [¹or is prescribed to prevent conception]. [²Benefits are provided only when the Prescription Order or Refill has been issued by a Network Physician or other Network provider.]

[Specialty Prescription Drug Products]

[Benefits are provided for Specialty Prescription Drug Products.]

[Applies to plan designs that include designated pharmacy.]

[If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.]

[If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Specialty Prescription Drug Product.]

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product [¹and Designated Pharmacy].

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.]

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Prescription Drugs from a Retail Non-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail non-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with us, as described in your *Certificate, Section 5: How to File a Claim*. We will not reimburse you for the difference between the Predominant Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail non-Network Pharmacy supply limits.

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[Applies to plan designs that include mail order.]

[Prescription Drug Products from a Mail Order Network Pharmacy]

[Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.]

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on mail order Network Pharmacy supply limits.

Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.]

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* apply also to this Rider, except that any preexisting condition exclusion in the *Certificate* is not applicable to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

[Variable exclusions below are plan design-specific.]

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- [3.] [\[Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.\]](#)
- [4.] Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- [5.] Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion will not apply to Prescription Drug Products approved by the *United States Food and Drug Administration (USFDA)* for use in the treatment of cancer on the basis that the Prescription Drug Product has not been approved by the *USFDA* for the treatment of the specific type of cancer for which the Prescription Drug Product has been prescribed, provided:
 - the Prescription Drug Product has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one or more compendia:
 - ◆ *the American Hospital Formulary Service Drug Information;*
 - ◆ *the United States Pharmacopoeia Dispensing Information;* or
 - the Prescription Drug Product has been recognized as safe and effective for treatment of that specific type of cancer in two articles from medical literature that have not had their recognition of the Prescription Drug Product's safety and effectiveness contraindicated by clear and convincing evidence in another article from medical literature.
 - Medical literature is defined as articles from major peer reviewed medical journals specified by the *United States Department of Health and Human Services*.
- [6.] Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- [7.] Prescription Drug Products for any condition, Injury, Sickness or [\[mental illness\]](#) [\[Mental Illness\]](#) arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- [8.] [\[Any product dispensed for the purpose of appetite suppression or weight loss.\]](#)

Contraceptives are mandated in AR, except for religious group employers. ¹Remove for religious employers who choose to exclude contraceptive coverage.

¹Include for groups that purchase contraceptive benefits. ²Include when immunizations administered in a pharmacy are covered under the Outpatient Pharmacy Rider. Select appropriate pharmacy or combination of pharmacies where coverage is provided.

- [9.] A Pharmaceutical Product for which Benefits are provided in your Certificate. [¹This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.] [²This exclusion does not apply to immunizations administered in a [Network] [,] [non-Network] [Network or non-Network] [or] [a Designated] Pharmacy.]
- [10.] Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- [11.] General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- [12.] Unit dose packaging of Prescription Drug Products.
- [13.] Medications used for cosmetic purposes.
- [14.] Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
- [15.] Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- [16.] Prescription Drug Products when prescribed to treat infertility.

Contraceptives are mandated in AR, except for religious group employers. ¹Include only for religious employers who choose to exclude contraceptive coverage and make corresponding changes to Schedule of Benefits.

- [¹17.] Prescription Drug Products when prescribed to prevent conception, including, but not limited to, oral contraceptives, diaphragms, Depo Provera and other injectable drugs used for contraception.]
- [18.] [Treatment for toenail Onychomycosis (toenail fungus).]

[¹Include for groups that purchase benefits for only certain smoking cessation products.]

- [19.] [[¹Certain] Prescription Drug Products for smoking cessation.]

[¹Applies when plan design includes compounds. ²Applies when plan design excludes compounds.]

- [20.] [¹Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier [2] [3] [4].)] [²Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.]

[¹Include when a prescription order/refill is required for coverage. ²Include if group purchases benefits for smoking cessation that include over-the-counter drugs.]

- [21.] [Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product [¹and it is obtained with a Prescription Order or Refill from a Physician]. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. [²This exclusion does not apply to over-the-counter drugs used for smoking cessation.]]

[22.] [Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our Prescription Drug List (PDL) Management Committee.]

[¹Applies when plan design excludes growth hormone therapy for all conditions. ²Applies when plan design includes limited benefits for growth hormone therapy.]

[23.] [¹Growth hormone therapy.] [²Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).]

[24.] [Any oral non-sedating antihistamine or antihistamine-decongestant combination.]

[25.] [Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.]

[26.] Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, **except that Medical Foods and Low Protein Food Products are covered for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias and disorders of amino acid metabolism if the products are prescribed and administered under the direction of a Physician.**

[27.] [A particular Therapeutic Class or Therapeutic Classes. Please access [www.myuhc.com] through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Therapeutic Class or Therapeutic Classes are excluded.]

[28.] [Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.]

[29.] [Prescription Drug Products when prescribed as sleep aids.]

[30.] [A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.]

[31.] [A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.]

[32.] Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

Section 3: Defined Terms

[Variable definitions below are plan design-specific.]

[Annual Drug Deductible - the amount you are required to pay for covered Prescription Drug Products in a year before we begin paying for Prescription Drug Products. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Drug Deductible applies.]

[¹Applies when plan design includes either the annual drug deductible or copayment option.]

[²Applies when plan design includes the annual drug deductible. ³Applies when plan design includes the copayment option.]

[Annual Out-of-Pocket Drug Maximum - the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Annual Out-of-Pocket Drug Maximum applies. [¹The Annual Out-of-Pocket Drug Maximum includes the [²Annual Drug Deductible] [³Copayment].]

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

[Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products[, including, but not limited to, Specialty Prescription Drug Products]. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.]

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

[¹Include when plan design includes specialty prescription drug program.]

[List of Preventive Medications - a list that identifies certain Prescription Drug Products [¹, which may include certain Specialty Prescription Drug Products,] on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may obtain the List of Preventive Medications through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our periodic review and modification.]

Maximum Per Drug Benefit - the maximum amount we will pay for any covered Prescription Order or Refill.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

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- The date it is assigned to a tier by our Prescription Drug List (PDL) Management Committee.
- December 31st of the following calendar year.

[¹Applies when plan design includes the copayment option.]

[Per Drug Out-of-Pocket Maximum - the maximum amount you are required to pay for a Prescription Order or Refill. [¹The Per Drug Out-of-Pocket Maximum includes the Copayment.])

Predominant Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. We calculate the Predominant Reimbursement Rate using our Prescription Drug Charge that applies for that particular Prescription Drug Product at most Network Pharmacies.

Applies when plan design includes mail order and MAC pricing.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy. [The Prescription Drug Charge for a Generic Prescription Drug Product dispensed by a mail order Network Pharmacy, however, will be the Maximum Allowable Cost (MAC) List price which may be higher or lower than the rate we have agreed to pay the mail order Network Pharmacy. We establish the Maximum Allowable Cost (MAC) List price. You may access the amount you will pay for a Brand-name or Generic Prescription Drug Product to be dispensed by a retail Network Pharmacy and/or a mail order Network Pharmacy through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card. Depending upon your plan design, the amount you will pay may be a Copayment or the Prescription Drug Charge.]

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- [Immunizations administered in a pharmacy.]
- The following diabetic supplies:
 - standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - lancets and lancet devices; and
 - glucose monitors.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

[Preventive Care Medications – the medications that are obtained at a Network Pharmacy [with a Prescription Order or Refill from a Physician] and that are payable at 100% of [the Prescription Drug Cost] [the cost] (without application of any Maximum Per Drug Benefit [,] [or] [Specialty Drug Maximum Per Drug Benefit] [,] [or] [Copayment] [,] [or] [Annual Deductible] [,] [or] [Annual Drug Deductible]) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.

[Applies if immunizations are covered under the pharmacy benefit:]

- [Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.]
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.]

You may determine whether a drug is a Preventive Care Medication through the internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. [Specialty Prescription Drug Products may include drugs on the List of Preventive Medications.] You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Therapeutic Class - a group or category of Prescription Drug Products with similar uses and/or actions.]

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Include when Exhibit 2 for more than one class of Eligible Persons is being amended.

Notice of Change to Exhibit 2 [Class [1-10]]

Effective [_____], the following provision(s) included in Exhibit 2 of this Policy are replaced by the provision(s) shown below.

Enter new or revised class description.

1. **[Class Description.**

[All full-time employees.]

Insert new or revised Eligibility conditions in A and B below. ¹Include when more than one class of Eligible Persons is covered.

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

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

[_____]

B. Other:

[_____]]

Insert new or revised Open Enrollment Period.

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

Insert new or revised Effective Date for Eligible Persons.

[4.] **[Effective Date for Eligible Persons.** For an Eligible Person who becomes eligible after the effective date of the Policy, his or her effective date of coverage is: [the day following the last day of the required waiting period.] [the first day of the month following the last day of the required waiting period.] [the date the Eligible Person joins the Enrolling Group.] [the first day of the month following the date the Eligible Person joins the Enrolling Group.][as determined by the Enrolling Group, _____].] Any required waiting period will not exceed 90 days.]

Insert new or revised Premium rates.

[5.] **[Schedule of Premium Rates.** The schedule of Premium rates payable by or on behalf of this class of Covered Persons as of [Effective Date] is shown below:

[Coverage Classification	Monthly Premium
Subscriber only	\$XXX.XX
Subscriber and spouse	\$XXX.XX
Subscriber plus one child	\$XXX.XX
Subscriber plus family	\$XXX.XX]]

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

[Monthly Premiums payable by or on behalf of Covered Persons are specified in the *Cost Summary* detailed through the new business premium confirmation process and renewal package.]

[Incentives for Health] Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides coverage under [Incentives for Health].

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms*.

[Enrolled Dependent spouse references are variable depending upon plan design.]

When we use the words "we," "us," and "our" in this document, we are referring to [UnitedHealthcare Insurance Company]. When we use the words "you" and "your" in this document we are referring to the Subscriber [and Enrolled Dependent spouse].

Identified below are the eligibility requirements that must be fulfilled in order to have access to the incentive plan.

Eligibility Requirements

^[1] Include when enrollment in the incentive plan is the first year and persons must meet criteria to keep the plan the next and subsequent years.]

^[2] Include when plan is outcome-based.]

Subscribers [and Enrolled Dependent spouses] must meet the criteria listed below to have access to the incentive plan [^[1]in the subsequent Policy year]. [^[2][Incentives for Health] will provide a reasonable alternative standard to qualify for the incentive plan to any individual for whom it is unreasonably difficult due to a medical condition or medically inadvisable to meet a specified target.]

[Incentive Requirement]	[Target]	[Reasonable Alternative Standard]
[Complete Health Risk Assessment]	[None] [Other]	[None] [Other]
[Create Electronic Personal Health Record and Make Available to Physician or Submit Documentation Evidencing Health History Discussion with Physician]	[None] [Other]	[None] [Other]
[Annual Wellness Visit with Physician to Include the Following Biometric Screenings:		
[Nicotine Status]	[No use of nicotine products for the past 6 months] [None] [Other]	[Discussion of biometric screening results with your Physician and written commitment from you to follow your Physician's recommended treatment plan.] [None] [Other]

[Incentive Requirement]	[Target]	[Reasonable Alternative Standard]
[Body Mass Index (BMI)]	[Between [x] and [x] kg/m ²] [None] [Other]	[Discussion of biometric screening results with your Physician and written commitment from you to follow your Physician's recommended treatment plan.] [None] [Other]
[Blood Pressure]	[<[x]/x] mm/Hg] [None] [Other]	[Discussion of biometric screening results with your Physician and written commitment from you to follow your Physician's recommended treatment plan.] [None] [Other]
[LDL Cholesterol]	[<[x] mg/dl] [None] [Other]	[Discussion of biometric screening results with your Physician and written commitment from you to follow your Physician's recommended treatment plan.] [None][Other]
[Fasting Blood Glucose (FBG) or A1c]	[FBG <[x] mg/dl or A1c < [x]%] [None][Other]	[Discussion of biometric screening results with your Physician and written commitment from you to follow your Physician's recommended treatment plan.] [None][Other]
[Others]	[Others]	[Others]
[Discussion of Biometric Screening Results with Physician and Commitment to Follow Any Treatment Plan]	[None][Other]	[None][Other]
[Signed Incentive Qualification Form by Subscriber and Physician [and Enrolled Dependent spouse and Physician]]	[None][Other]	[None][Other]

[Incentive Requirement]	[Target]	[Reasonable Alternative Standard]
[Others]	[Others]	[Others]

Subsequent Eligibility Requirements

[¹Include when plan is outcome-based.]

To remain eligible for the incentive plan in subsequent Policy years, Subscribers [and Enrolled Dependent spouses] must meet the following criteria listed below. [¹[Incentives for Health] will provide a reasonable alternative standard to qualify for the incentive plan to any individual for whom it is unreasonably difficult due to a medical condition or medically inadvisable to meet a specified target.]

[Incentive Requirement]	[Target]	[Reasonable Alternative Standard]
[Updated Health Risk Assessment]	[None][Other]	[None][Other]
[Maintain Electronic Personal Health Record and Make Available to Physician or Submit Documentation Evidencing Health History Discussion with Physician]	[None][Other]	[None][Other]
[Annual Wellness Visit with Physician to Include the Following Biometric Screenings:		
[Nicotine Status]	[No use of nicotine products for the past 6 months] [None][Other]	[Discussion of biometric screening results with your Physician, written commitment from you to follow your Physician's recommended treatment plan and documentation from your Physician that you are following the recommended treatment plan and were unable to meet the target due to a medical condition.] [None][Other]
[Body Mass Index (BMI)]	[Between [x] and [x] kg/m2 or evidence that you dropped to a lower class of obesity from the previous year based on the following classes:	[Discussion of biometric screening results with your Physician, written commitment from you to follow your Physician's

[Incentive Requirement]	[Target]	[Reasonable Alternative Standard]
	Class I Obesity – between [x] and [x] kg/m ² ; Class II – between [x] and [x] kg/m ² ; Class III – [x] kg/m ² or greater [None][Other]	recommended treatment plan and documentation from your Physician that you are following the recommended treatment plan and/or are actively participating in a weight loss and/or exercise and nutrition program and were unable to meet the target due to a medical condition.] [None][Other]
[Blood Pressure]	<[x/x] mm/Hg or Physician recommended blood pressure level] [None][Other]	[Discussion of biometric screening results with your Physician, written commitment from you to follow your Physician's recommended treatment plan and documentation from your Physician that you are following the recommended treatment plan and were unable to meet the target due to a medical condition.] [None][Other]
[LDL Cholesterol]	<[x] mg/dl or Physician recommended LDL cholesterol level] [None][Other]	[Discussion of biometric screening results with your Physician, written commitment from you to follow your Physician's recommended treatment plan and documentation from your Physician that you are following the recommended treatment plan and/or are actively participating in an

[Incentive Requirement]	[Target]	[Reasonable Alternative Standard]
		appropriate condition management program and were unable to meet the target due to a medical condition.] [None][Other]
[Fasting Blood Glucose (FBG) or A1c]	[FBG <[x] mg/dl or A1c < [x]% or Physician recommended FBG or A1c level] [None][Other]	[Discussion of biometric screening results with your Physician, written commitment from you to follow your Physician's recommended treatment plan and documentation from your Physician that you are following the recommended treatment plan and/or are actively participating in an appropriate condition management program and were unable to meet the target due to a medical condition.] [None][Other]
[Others]	[Others]	[Others]
[Signed Incentive Qualification Form by Subscriber and Physician [and Enrolled Dependent spouse and Physician]]	[None][Other]	[None][Other]
[Others]	[Others]	[Others]

Eligibility Reconsideration Rights Under the [Incentives for Health] Program

Your eligibility for the incentive plan is based upon a determination of whether you [and your Enrolled Dependent spouse] have met the criteria as set forth in this Rider. You [and your Enrolled Dependent spouse] can dispute this determination and request a reconsideration by providing evidence that you have successfully satisfied all of the criteria. This evidence may include documentation from your Physician certifying any corrected results and/or services or tests received that qualify for eligibility in the incentive plan. Requests for determination reconsideration must be made no later than 90 days prior to the end of the Policy year in which the incentive eligibility determination was made.

(Name and Title)

SERFF Tracking Number: UHLC-126931158

State: Arkansas

Filing Company: UnitedHealthcare Insurance Company

State Tracking Number: 47439

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: AR 2011 COC et. al

Project Name/Number: /

Rate data does NOT apply to filing.

SERFF Tracking Number: UHLC-126931158

State: Arkansas

Filing Company: UnitedHealthcare Insurance Company

State Tracking Number: 47439

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: AR 2011 COC et. al

Project Name/Number: /

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	01/28/2011
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Application	Approved-Closed	01/28/2011
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	01/28/2011
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Outline of Coverage	Approved-Closed	01/28/2011
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	01/28/2011
Bypass Reason:	N/A		
Comments:			

SERFF Tracking Number: UHLC-126931158 State: Arkansas
Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 47439
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: AR 2011 COC et. al
Project Name/Number: /

Item Status: Approved-Closed
Status Date: 01/28/2011
Satisfied - Item: Cover Letter
Comments:
Attachment:
AR INS 2011 Cover Letter.pdf

Item Status: Approved-Closed
Status Date: 01/28/2011
Satisfied - Item: Forms List
Comments:
Attachment:
AR INS 2011 FORMS LIST.pdf

Item Status: Approved-Closed
Status Date: 01/28/2011
Satisfied - Item: COC Redline
Comments:
Attachment:
AR 2011 COC Redline 01.18.10.pdf

December 2, 2010

Ms. Rosalind Minor
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
Re: UnitedHealthcare Insurance Company
NAIC No. 79413
Group Health Forms POL.I.11.AR et al.

Dear Madam/Sir:

On behalf of UnitedHealthcare Insurance Company, I am submitting the enclosed group health forms for your Department's review and approval. These documents are new forms and are not being filed to replace any form previously approved in your state.

Our intent is to use these forms for large and small employer groups. Similar forms are part of a nationwide filing. Because the enclosed forms have been modified to reflect the laws and regulations of Arkansas, they will not be filed with Connecticut, our State of Domicile.

These new forms incorporate the following legislative requirements.

Health Care Reform - Patient Protection and Affordable Care Act (PPACA) requirements including the following:

- Coverage provided for enrolled dependent children until age 26.
- The preexisting condition exclusion does not apply to covered persons under the age of 19.
- No aggregate lifetime benefit limits apply [and restricted annual limits may apply to Essential Benefits as defined under PPACA].
- Network Preventive care services, which are those services recommended by the U.S. Preventive Services Task Force (USPSTF), are not subject to any copayment, coinsurance or deductible provisions.
- Dependent Children/Dependent Child Special Open Enrollment Period provision included to allow the required 30 day opportunity for those children who are not currently enrolled at the time of renewal and have not met the limiting age of 26.
- Rescission limited only to instances of fraud or intentional misrepresentation of a material fact.
- Right to appeal a rescission of coverage determination.
- Right of covered persons to access new or additional evidence that was relied upon or generated by us during a determination of an appeal.
- The inclusion of a federal external review process.
- Direct access to OB/GYN care without a referral or authorization requirement.
- The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
- The ability to designate any primary care physician (PCP) that is accepting new patients.
- Prior authorization is not required before receipt of services in the emergency department of a hospital.

- Non-network benefits for hospital emergency room treatment are subject to the same cost sharing as Network benefits.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requirements:

The forms support federal mental health parity requirements by providing parity with medical and surgical benefits for large employer groups.

Forms for Which We Seek Approval

The forms for which we seek approval are identified on the attached “Forms Listing.” The readability/Flesch score is provided as well.

These materials represent final printed format (with the exception of variable text—please see the following paragraphs for explanation). Once approved, these forms will be used to support the issuance of our portfolio of group health products offered in your state. For a description of our products, please see the enclosed product description.

Explanation of Insert Forms and Variable Text

The forms contained in this filing are to be used on an insert form basis. [In lieu of filing modifications via amendments, the insert form(s) impacted by the modification will be submitted for review and approval.] Please refer to the “Forms Listing” for all of the forms to be used in conjunction with this new policy/certificate series.

Each insert form is made up of:

- Non-variable Text that always appears in an issued document.
- Variable Text that may or may not appear in an issued document depending on the specific product and plan design selected by the Enrolling Group. Variable text is enclosed in [brackets]. Brackets do not appear in the document issued to a member.

Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online viewing or issuance. We want to assure the Department that education will be provided to the brokers, employer groups and the employees regarding access and alternatives to electronic issuance.

If you have any questions or concerns regarding this submission, please feel free to call me at the number shown below.

Sincerely,

Ebony N. Terry
Compliance Analyst
UnitedHealthcare Insurance Company

800 King Farm Blvd.
Suite 600

Rockville, MD 20850
Ph: 240.632.8056

Toll free: 800-250-6180 Ext. [28056]
Email: Ebony_N_Terry@uhc.com

Forms Listing For UnitedHealthcare Insurance Company

Form Number	Description of Forms	Flesch or Readability Score
	Employer Policy	
POL.I.11.AR	Group Policy	50.0
EXB2NTC.I.11.AR	Notice of Change to Exhibit 2	68.6
	Member Certificate of Coverage	
COC.I.11.AR	Certificate of Coverage	51.2
	Schedules of Benefits	
SBN.CHC.I.11.AR	Schedule of Benefits for Choice	50.2
SBN.CHP.I.11.AR	Schedule of Benefits for Choice Plus	50.0
SBN.NDF.I.11.AR	Schedule of Benefits for Non-Differential PPO	49.2
SBN.OPT.I.11.AR	Schedule of Benefits for Options PPO	50.0
RDR.IFH.I.11.AR	Incentives for Health Rider	48.5
RDR.RX.PLS.I.11.AR	Outpatient Prescription Drug Rider (Net/Non-Net)	52.2
RDR.RXSBN.PLS.I.11.AR	Outpatient Prescription Drug Rider Schedule of Benefits(Net/Non-Net)	44.4
RDR.GENRX.PLS.I.11.AR	Outpatient Prescription Drug Rider- Generic RX (Net/Non-Net)	51.8
RDR.GENRXSBN.PLS.I.11.AR	Outpatient Prescription Drug Rider- Generic RX Schedule of Benefits(Net/Non-Net)	53.9
RDR.SHARERX.PLS.I.11.AR	Outpatient Prescription Drug Rider- Share RX (Net/Non-Net)	52.0
RDR.SHARERXSBN.PLS.I.11.AR	Outpatient Prescription Drug Rider- Share RX Schedule of Benefits(Net/Non-Net)	71.4

Certificate of Coverage

UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy

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

In addition to this *Certificate* the Policy includes:

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

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

Changes to the Document

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

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

Other Information You Should Have

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

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

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

We are delivering the Policy in the State of [\[State Name Here\]](#). The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of [\[State Name Here\]](#) are the laws that govern the Policy.

Introduction to Your Certificate

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

How to Use this Document

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

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

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

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

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

Information about Defined Terms

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

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

Don't Hesitate to Contact Us

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

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

Arkansas Insurance Department
[Consumer Services Division]
[1200 West Third Street]
[Little Rock, AR 72201-1904]
[(800) 852-5494] or [(501) 371-2640]

Your Responsibilities

Be Enrolled and Pay Required Contributions

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

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

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

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

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

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

[Product Variables:]

¹Choice Plus or Options PPO when network providers are responsible for prior authorization.]

²Choice.]

³Options PPO when network providers are not responsible for prior authorization or Non-Differential PPO when prior authorization is required for any service.]

Some Covered Health Services require prior authorization. *[¹In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services.] [²In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services.] [³You are responsible for obtaining authorization before you receive the services.]* For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

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

Pay the Cost of Excluded Services

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

Show Your ID Card

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

File Claims with Complete and Accurate Information

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

Use Your Prior Health Care Coverage

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

Our Responsibilities

Determine Benefits

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

We have the discretion to do the following:

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

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

Pay for Our Portion of the Cost of Covered Health Services

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

Pay Network Providers

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

Pay for Covered Health Services Provided by Non-Network Providers

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

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

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

Offer Health Education Services to You

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

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Section 1: Covered Health Services

Benefits for Covered Health Services

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

[Here and throughout the document, the defined term (capitalized) applies if Mental Health Benefits are sold, lower case reference applies if Mental Health Benefits are not sold.]

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 9: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, **[Mental Illness.] [mental illness.]** substance use disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Policy.
- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

[Bracketed plan features are plan design variable.]

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

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

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

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design. Include any other specific conditions for coverage described within the category.]

[1.] [Acupuncture Services]

[Acupuncture services for the following conditions:

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

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

- Doctor of Medicine.
- Doctor of Osteopathy.

- [Chiropractor.](#)
- [Acupuncturist.\]](#)

[2.] Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where Emergency Health Services can be performed.

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

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

[3.] Clinical Trials

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

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

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

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

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

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

Routine patient care costs for clinical trials include:

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

Routine costs for clinical trials do not include:

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

- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

- Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.
 - *Centers for Medicare and Medicaid Services (CMS)*.
 - *Department of Defense (DOD)*.
 - *Veterans Administration (VA)*.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

[4.] [Congenital Heart Disease Surgeries]

[Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

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

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

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

[5.] [Dental Services - Accident Only]

[Dental services when all of the following are true:

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

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

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

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

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

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.]

[6.] Diabetes Services

Diabetes Self-Management Training is mandated in Arkansas.

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

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

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

Diabetic Self-Management Items

[Include paragraph below when group purchases the drug rider.]

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

[Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. ^[1]An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment.*] Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider.*]

[Include paragraph and bulleted list below when group does not purchase the drug rider.]

^[1]*Include only when group does not purchase benefits for durable medical equipment.]*

^[2]*Include only when group purchases benefits for durable medical equipment.]*

[Insulin pumps ^[1]that are not fully implanted into the body] and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including:

- ^[2]Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment.*]
- Blood glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.]

[7.] [Durable Medical Equipment]

[Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

[Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.]

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

[Include when DME benefit is tiered and tiers are not to be included in COC.]

[To determine the Tiers to which Durable Medical Equipment are assigned, contact [www.myuhc.com] or Customer Care at the telephone number on your ID card.]

[Include when DME benefit is tiered and tiers are to be included in COC.]

[Durable Medical Equipment in Tier 1 is any item not specifically outlined in Tiers 2 or 3 below.

Durable Medical Equipment in Tier 2 is limited to the items listed below and any necessary supplies:

- Oxygen.
- Tube feeding pumps.
- Negative pressure wound therapy pumps (wound vacuums).
- Bi-level Positive Airway Pressure machines (BiPAPs).
- Bone growth stimulators.
- Pulse oximeters.
- Wearable automatic external defibrillators.
- Insulin pumps.
- Neuromuscular stimulators that we determine to be proven for use, and which are used as part of an approved rehabilitative program.
- [Speech aid devices and tracheo-esophageal voice devices.]

Durable Medical Equipment in Tier 3 is limited to the items listed below and any necessary supplies:

- Power wheel chairs.
- Ventilators.
- High frequency chest compression devices.
- Specialty beds for pressure reduction.]]

[8.] Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

[Include if plan design includes retrospective review of emergency services.]

[Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.]

Include as standard for groups of 2 to 15 and 15+.

[9.] Hearing Aids

[Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this *Certificate*, only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.]

[10.] Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

[11.] Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

[12.] Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

[13.] [Infertility Services]

[Services for the treatment of infertility when provided by or under the direction of a Physician, limited to the following procedures:

- Ovulation induction.
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Assisted Reproductive Technologies (ART).
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

To be eligible for Benefits, the Covered Person must meet all of the following:

- Have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35.
- Be under age 44, if female.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.]

[14.] Lab, X-Ray and Diagnostics - Outpatient

[Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office.]

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility *[or in a Physician's office]* include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

[Include when plan design supports paying the physician's office services benefit for Lab/X-ray performed in a physician's office.]

*[When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]*

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient*.

[15.] Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

[Include when plan design has an office visit copayment and supports paying CT, PET, MRI, MRA and nuclear medicine benefit for services performed in a physician's office.]

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility *[or in a Physician's office]*.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.

- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.*)

[Include when plan design supports paying the physician's office services benefit for major diagnostics performed in a physician's office.]

[When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury.*]

[Include as standard for groups of 2 to 15]

[16.] [Mental Health Services]

[Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.]

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.]

[17.] [Neurobiological Disorders - Autism Spectrum Disorder Services]

[Psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.

- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available [1 under the applicable medical Covered Health Services categories in this Certificate] [2 as described under [autism benefit section name] below].

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

[Include when expanded services for autism are required by state law. If there is not a state mandate requiring coverage ABA, delete this provision. It is not available for sale at a group specific level.]

[Note to contract specialist: This section should only be utilized to support the mental health component of state mandates for autism spectrum disorders for intensive behavioral therapies such as ABA. Delete this instruction prior to filing.]

[Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).]

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.]

[18.] [Obesity Surgery]

[Include the applicable criteria for coverage].

[Surgical treatment of obesity when provided by or under the direction of a Physician [when the Covered Person has a body mass index (BMI) greater than 40].

[Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met:

- [The Covered Person must have a body mass index (BMI) of greater than 40.]
- [The Covered Person must have a body mass index (BMI) of greater than 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by, obesity.]]

[19.] [Ostomy Supplies]

[Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.]

[20.] Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. [Benefits under this section do not include medications for the treatment of infertility.]

[Pharmaceutical Products are assigned to various tiers. The Pharmaceutical Product List Management Committee makes the final classification of a Pharmaceutical Product to a certain tier by considering a number of factors including clinical and economic factors. Clinical factors may include evaluations of the place in therapy, relative safety or relative efficacy of the Pharmaceutical Product, as well as whether prior authorization requirements should apply. Economic factors may include the Pharmaceutical Product's acquisition cost, including available rebates and assessments on the cost effectiveness of the Pharmaceutical Product.

Note: We may periodically change the placement of a Pharmaceutical Product among the tiers. These changes generally occur quarterly, but no more than six times per year. These changes may occur without prior notice to you. As a result of such changes, the tier status of a Pharmaceutical Product may change, and you may be required to pay more or less for that Pharmaceutical Product.

To determine the tiers to which Pharmaceutical Products are assigned, contact [www.myuhc.com] or *Customer Care* at the telephone number on your ID card. The amount that you are required to pay for Pharmaceutical Products will vary depending upon the tier to which the Pharmaceutical Product is assigned.]

[If you require certain Pharmaceutical Products[, including specialty Pharmaceutical Products,] we may direct you to a Designated Dispensing Entity with whom we have an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

[¹Applies to Choice Plus and Options PPO products.]

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, [¹Network] Benefits are not available for that Pharmaceutical Product.]

[Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or prescription drug product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Benefits for certain Pharmaceutical Products are subject to the supply limits that are stated in the *Schedule of Benefits*. For a single Copayment and/or Coinsurance, you may receive Pharmaceutical Products up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per order or refill and/or the amount dispensed per month's supply.

You may determine whether a Pharmaceutical Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

[21.] Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

[22.] Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

[¹Include when Genetic Testing must be preceded by genetic counseling.]

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is [¹determined to be Medically Necessary following genetic counseling when] ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

[Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office. ²Include when only minor diagnostics are included under Physician's Office Services, but major diagnostics in a Physician's office are paid under the major diagnostic category.]

[Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. [²Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.]]

[Include when plan design supports paying Benefits for lab/X-ray only under the Lab/X-ray benefit.]

[When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.]

[¹Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude.]

^[2]If Maternity Services are excluded, Complications of Pregnancy must always be included.]

[23.] Pregnancy - [¹Maternity Services] [²Complications of Pregnancy only]

^[1]Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.]

^[2]Benefits for Complications of Pregnancy include all Covered Health Services required for the non-obstetrical treatment of a condition related to a Complication of Pregnancy during a Pregnancy or during the post-partum period.

Both before and during a Pregnancy, Benefits are provided for the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We will pay Benefits for an Inpatient Stay of at least 96 hours for the mother and newborn child following a non-elective cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than this minimum time frame.]

[24.] Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Prosthetics are a mandated benefit in Arkansas.

[25.] Prosthetic Devices and Services

Benefits are available for the evaluation and treatment of a condition that requires the use of a prosthetic device. Benefits are available for external prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement when necessitated by anatomical change or normal use except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

[26.] Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]

[Short-term outpatient rehabilitation services, limited to:

- Physical therapy.
- Occupational therapy.
- [Manipulative Treatment.]
- Speech therapy.
- Pulmonary rehabilitation therapy.

- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.
- [Vision therapy.]

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. [Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.]

[Here and throughout the document, include defined capitalized term if plan design includes benefits for neurobiological disorder/autism spectrum disorder services. Include lower case reference if plan design does not include benefits for neurobiological disorder/autism spectrum disorder services.]

Please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or [autism spectrum disorders] [Autism Spectrum Disorders]. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.]

[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic

[Include when plan design has an office visit copayment and supports paying the scopic benefit for services performed in a physician's office.]

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility [\[or in a Physician's office\]](#).

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

[Include when plan design does not support paying the scopic procedures benefit for services performed in a physician's office.]

[\[When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.\]](#)

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

[Include as standard for groups of 2 to 15]

[30.] Substance Use Disorder Services

[Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.]

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.]

[31.] Surgery - Outpatient

[¹Include when plan design has an office visit copayment and supports paying the outpatient surgery benefit for services performed in a physician's office.]

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility [¹or in a Physician's office].

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

[¹Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.]

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

[Include when plan design supports paying the physician's office services benefit for outpatient surgery performed in a physician's office.]

[When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

[32.] Temporomandibular Joint Services

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.

[33.] Therapeutic Treatments - Outpatient

[Include when plan design has an office visit copayment and supports paying the therapeutic treatments benefit for services performed in a physician's office.]

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility [\[or in a Physician's office\]](#), including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

[Include when plan design supports paying the physician's office services benefit for therapeutic treatments performed in a physician's office.]

*[When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]*

[34.] Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

[35.] Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

[36.] [Vision Examinations]

[\[Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office.\]](#)

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.]

[37.] [Wigs]

[Wigs and other scalp hair prosthesis regardless of the reason for hair loss.]

Additional Benefits Required By Arkansas Law

[38.] Dental Services - Anesthesia and Hospitalization

Covered Health Services for anesthesia and related hospital services in conjunction with a dental procedure, if the anesthesia and related hospital services are deemed medically necessary by the patient's Physician or dentist and the following conditions are met:

- The patient is a child age seven or younger who is diagnosed with a dental condition that requires certain dental procedures to be performed in a Hospital or Alternate Facility.
- The patient is diagnosed with a serious mental or physical condition or a significant behavioral problem as determined by the patient's Physician.

[39.] In Vitro Fertilization Services

Covered Health Services for in vitro fertilization services. Cryopreservation, the procedure whereby embryos are frozen for late implantation, will be included as an in vitro fertilization procedure. The coverage will include services performed at:

- A medical facility licensed or certified by the *Arkansas Department of Health*.
- A facility certified by the *Arkansas Department of Health* that conforms to the *American College of Obstetricians and Gynecologists* guidelines for in vitro fertilization clinics.
- A facility certified by the *Arkansas Department of Health* which meets the *American Fertility Society* minimal standards for programs of in vitro fertilization.

[40.] Medical Foods

Coverage for medical Foods and Low Protein Modified Food Products which are for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism and administered under the direction of a Physician is provided if the cost of the medical Foods and Low Protein Modified Food Products for an individual or a family with a Dependent person or persons exceeds the \$2,400 per year, per person income tax credit. If the cost of these products does not exceed the per person income tax credit, Benefits are not provided.

This is a mandated offer in Arkansas. If group chooses not to have this benefit, they must refuse this benefit in writing.

[[41.] Musculoskeletal Disorders of the Face, Neck or Head]

[Diagnosis and treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder, whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. Treatment will also include both surgical and non-surgical procedures. Coverage will be the same as that provided for any other musculoskeletal disorder in the body and will be provided whether prescribed or administered by a Physician or dentist.]

[[42.] Orthotic Devices and Services

Benefits are available for the evaluation and treatment of a condition that requires the use of an orthotic device.

Benefits are available for external orthotic devices that restore physiological function or cosmesis to you.

If more than one orthotic device can meet your functional needs, Benefits are available only for the orthotic device that meets the minimum specifications for your needs. If you purchase a orthotic device

that exceeds these minimum specifications, we will pay only the amount that we would have paid for the orthotic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The orthotic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement when necessitated by anatomical change or normal use except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen orthotic devices.

Orthotic devices do not include a cane, crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that:

- Is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and
- Has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

This exclusion does not apply to orthotics that are described under Orthotic Devices and Services in Section 1: Covered Health Services.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services* or through a Rider to the Policy.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

[Include bracketed variable exclusions below to support plan design. Unbracketed exclusions will always appear.]

A. Alternative Treatments

1. Acupressure [\[and acupuncture\]](#).
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to [\[Manipulative Treatment and\]](#) non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). [\[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1: Covered Health Services.\]](#) [Dental Services - Anesthesia and Hospitalization for which Benefits are provided as described in Section 1: Covered Health Services.](#)

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only in Section 1: Covered Health Services.*] *Dental Services - Anesthesia and Hospitalization for which Benefits are provided as described in Section 1: Covered Health Services.*

3. Dental implants, bone grafts and other implant-related procedures. [This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only in Section 1: Covered Health Services.*] *Dental Services - Anesthesia and Hospitalization for which Benefits are provided as described in Section 1: Covered Health Services.*
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. *This exclusion does not apply to orthotics as described under Durable Medical Equipment in Section 1: Covered Health Services.*
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses.
 - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech [except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment in Section 1: Covered Health Services.*]
6. Oral appliances for snoring.

[7.] *Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.*

[8.] Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
 2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
 3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
 4. Over-the-counter drugs and treatments.
 5. Growth hormone therapy.
- [6.] [Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.]
- [7.] [New Pharmaceutical Products and/or new dosage forms until the date they are assigned to a tier by our Pharmaceutical Product List Management Committee.]

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
 2. Nail trimming, cutting, or debriding.
 3. Hygienic and preventive maintenance foot care. Examples include:
 - Cleaning and soaking the feet.
 - Applying skin creams in order to maintain skin tone.
- This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
 5. Treatment of subluxation of the foot.
 6. Shoes.
 7. Shoe orthotics.
 8. Shoe inserts.
 9. Arch supports.

^[1]Applies when plan design does not include benefits for durable medical equipment.]

^[2]Applies when plan design includes benefits for durable medical equipment.]

G. Medical Supplies [¹and Equipment]

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:

- Compression stockings.
- Ace bandages.
- Gauze and dressings.
- Urinary catheters.
- [Ostomy supplies.]

This exclusion does not apply to:

- [²Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.]
- Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
- [Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.]

2. Tubings and masks [²except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*].

[3.] [¹Medical equipment of any kind. This exclusion does not apply to insulin pumps for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.]

H. Mental Health

[Introductory sentence and exclusions 1-9 apply when plan design includes benefits for mental health services.]

[Exclusion 10 applies when plan design does not include benefits for mental health services. Renumber exclusion to #1.]

*[Exclusions listed directly below apply to services described under *Mental Health Services* in *Section 1: Covered Health Services*.]*

- [1.] [Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]
- [2.] [Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]
- [3.] [Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.]
- [4.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.]
- [5.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.]
- [6.] [Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.]
- [7.] [Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]
- [8.] [Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits

for autism spectrum disorder as a primary diagnosis are described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.]

- [9.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
 - Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.]

[¹Applies when the group provides benefits for mental health services under a separate plan.]

- [10.] [Services for the treatment of mental illness or mental health conditions [¹that the Enrolling Group has elected to provide through a separate benefit plan].]

I. Neurobiological Disorders - Autism Spectrum Disorders

[Introductory sentence and exclusions 1-8 apply when plan design includes benefits for neurobiological disorder/autism spectrum disorder services.]

[Exclusion 9 applies when plan design does not include benefits for neurobiological disorder/autism spectrum disorder services. Renumber exclusion to #1.]

[Exclusions listed directly below apply to services described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.]

- [1.] [Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]
- [2.] [Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.]
- [3.] [Mental retardation as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]
- [4.] [Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.]
- [5.] [Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.]
- [6.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.]

[Applies when plan design does not include benefits for expanded autism spectrum disorder.]

- [7.] [Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder.]
- [8.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.

- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.]

[Applies when plan design does not include benefits for neurobiological disorder/autism spectrum disorder services.]

[¹Applies when the group provides benefits for autism spectrum disorders under a separate plan.]

[9.] [Services for the treatment of autism spectrum disorders as the primary diagnosis [¹that the Enrolling Group has elected to provide through a separate benefit plan]. (Autism spectrum disorders are a group of neurobiological disorders that includes *Autistic Disorder, Rhetts Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).*)]

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
 - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
 - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
2. Enteral feedings, even if the sole source of nutrition. **This exclusion does not apply to medical foods for which Benefits are provided as described in Section 1: Covered Health Services**
3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners, air purifiers and filters and dehumidifiers.
 - Batteries and battery chargers.
 - Breast pumps.
 - Car seats.
 - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
 - Exercise equipment.

- Home modifications such as elevators, handrails and ramps.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.

[5.] [Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.]

[6.] [Wigs regardless of the reason for the hair loss.]

[Applies when plan design does not provide benefits for pre-existing conditions.]

[M.] [Preexisting Conditions]

[A 12-month preexisting condition exclusion applies to all covered persons age 19 and older.]

[1.] [Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months. This exclusion does not apply to Covered Persons under age 19.]

[A 12-month preexisting condition exclusion applies to timely adds and an 18-month preexisting condition exclusion to late enrollees.]

[1.] [Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following:

- The date you have had Continuous Creditable Coverage for 12 months.
- The date you have had Continuous Creditable Coverage for 18 months if you are a Late Enrollee.

This exclusion does not apply to Covered Persons under age 19.]

[A preexisting condition exclusion applies to late enrollees only.]

[1.] [Benefits for the treatment of a Preexisting Condition are excluded for Late Enrollees until the date you have had Continuous Creditable Coverage for [12] [18] months. This exclusion does not apply to Covered Persons under age 19.]

[N.] Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

[Applies when plan design includes benefits for rehabilitation services.]

[4.] [Rehabilitation services [and Manipulative Treatment] to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.]

[Applies when plan design includes benefits for rehabilitation services.]

[5.] [Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or [autism spectrum disorders] [Autism Spectrum Disorders].]

[Applies when plan design includes benefits for rehabilitation services.]

[6.] [Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.]

[Applies when plan design does not include benefits for rehabilitation services.]

[5.] [Outpatient rehabilitation services. Examples include physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy, manipulative treatment, post-cochlear implant aural therapy, cognitive rehabilitation therapy and vision therapy.]

[6.] Psychosurgery.

- [7.] Sex transformation operations and related services.
- [8.] Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
- [9.] Biofeedback.

[Applies when plan design does not include benefits for manipulative treatment.]

- [10.] [Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function).]

[Applies when plan design does not include benefits for TMJ.]

- [11.] [Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.]

[Applies when plan design includes benefits for TMJ.]

- [11.] [The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.]

¹Include if group purchases optional benefit for Musculoskeletal Disorders.

- [12.] Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury, dislocation, tumors or cancer. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea. [¹This exclusion does not apply to Musculoskeletal Disorders of the Face, Neck or Head for which Benefits are provided as described in Section 1: Covered Health Services under Additional Benefits Required By Arkansas Law.]

- [13.] [Surgical and non-surgical treatment of obesity.] [Non-surgical treatment of obesity.] [Surgical treatment of obesity.]

- [14.] Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

[Applies when plan design does not include benefits for breast reduction.]

- [15.] [Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1: Covered Health Services.]

[Applies when plan design includes benefits for breast reduction.]

- [16.] [Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1: Covered Health Services.]

[Applies when plan design requires that implantation of ventricular assist devices be performed at a Designated Facility.]

- [17.] [Ventricular assist device implantation that is not performed at a Designated Facility. This exclusion does not apply to partial assist devices which are intended for short-term purposes or to Emergency implantations of partial assist devices.]

[Applies when plan design requires that Network Benefits for implantation of ventricular assist devices be performed at a Designated Facility.]

[18.] [Network Benefits for ventricular assist device implantation that is not performed at a Designated Facility. This exclusion does not apply to partial assist devices which are intended for short-term purposes or to Emergency implantations of partial assist devices.]

[O.] Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
 - Has not been actively involved in your medical care prior to ordering the service, or
 - Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography.

[P.] Reproduction

[Applies when plan design does not include benefits for infertility treatment.]

1. [Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. **except for In Vitro Fertilization Services for which Benefits are provided as described in Section 1: Covered Health Services.** This exclusion does not apply to services required to treat or correct underlying causes of infertility.]

[Applies when plan design includes benefits for infertility treatment.]

[The following infertility treatment-related services:

- Cryo-preservation and other forms of preservation of reproductive materials.
 - Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
 - Donor services.]
2. Surrogate parenting, donor eggs, donor sperm and host uterus.

[Applies when plan design does not include benefits for infertility treatment.]

3. [Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.]

[4.] The reversal of voluntary sterilization [and voluntary sterilization].

[5.] [Health services and associated expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).]

[6.] [Contraceptive supplies and services.]

[Will not apply when plan design includes benefits for infertility treatment.]

[7.] [Fetal reduction surgery.]

[Applies when plan design does not include full maternity benefits. This option is available only to groups with 14 or fewer employees.]

[8.] [Maternity related medical services for prenatal care, postnatal care and delivery (other than a non-elective cesarean delivery).]

[9.] [Maternity related medical services for Enrolled Dependent children.]

[Q.] Services Provided under another Plan

[Applies when plan design does not include benefits for 24 hour coverage.]

1. [Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or [Mental Illness] [mental illness] that would have been covered under workers' compensation or similar legislation had that coverage been elected.]

[Applies when plan design includes benefits for 24 hour coverage.]

[Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes coverage required by workers' compensation, no-fault auto insurance, or similar legislation. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.]

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

[R.] Substance Use Disorders

[Introductory sentence and exclusions 1-4 apply when plan design includes benefits for substance use disorder services.]

[Exclusion 5 applies when plan design does not include benefits for substance use disorder services. Renumber exclusion to #1.]

[Exclusions listed directly below apply to services described under *Substance Use Disorder Services in Section 1: Covered Health Services.*]

- [1.] [Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*]
- [2.] [Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.]
- [3.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.]
- [4.] [Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.

- Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.]

[Applies when plan does not include benefits for substance use disorders.]

[¹Applies when the group provides benefits for substance use disorders under a separate plan.]

- [5.] [Services for the treatment of substance use disorder services [¹that the Enrolling Group has elected to provide through a separate benefit plan].]

[S.] Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.

[Applies to Network-only plans and to plans with Network and Non-Network benefits when Non-Network transplant benefits are not available and plan design requires transplants to take place at Designated Facilities.]

- [4.] [Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.]

[T.] Travel

1. [Health services provided in a foreign country, unless required as Emergency Health Services.]
- [2.] Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services*.

[U.] Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services*.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

[V.] Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses.

- [2.] [Routine vision examinations, including refractive examinations to determine the need for vision correction.]
- [3.] Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
- [4.] [Eye exercise or vision therapy.]
- [5.] Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.

[Applies when plan design provides benefits for hearing aids.]

- [6.] [Bone anchored hearing aids except when either of the following applies:
 - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
 - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy.

Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.]

[Applies when plan design does not provide benefits for hearing aids.]

- [6.] [Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.]

[W.] All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - ♦ Medically Necessary.
 - ♦ Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
 - ♦ Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
 - Required solely for purposes of school, sports or camp[, travel,] [career or employment,] insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.
 - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services.
11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins

How to Enroll

Eligible Persons must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the completed forms to us, along with any required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

[Applies when plan design includes Medicare estimating.]

[If You Are Eligible for Medicare]

[Your Benefits under the Policy may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under [both Medicare Part A and Part B] [Medicare Part A, Part B and Part D] [Medicare Part D].

Your Benefits under the Policy may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but fail to follow the rules of that plan. Please see *Medicare Eligibility* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.]

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Enrolling Group who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see *Section 9: Defined Terms*.

[Eligible Persons must reside within the United States.]

[If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.]

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

[If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.]

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Enrolling Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

[Applies when the Incentives for Health Rider is sold.]

[During this Initial Enrollment Period, the Enrolling Group will offer an incentive plan as described in the [Incentives for Health] Rider which is attached to this Certificate. In order to enroll in the [Incentives for Health] [in subsequent years] you must meet the eligibility requirements stated in the Rider.]

[Open Enrollment Period]

[The Enrolling Group determines the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.]

Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.]

Dependent Child Special Open Enrollment Period

On or before the first day of the first plan year beginning on or after September 23, 2010, the Enrolling Group will provide a 30 day dependent child special open enrollment period for Dependent children who are not currently enrolled under the Policy and who have not yet reached the limiting age. During this dependent child special open enrollment period, Subscribers who are adding a Dependent child and who have a choice of coverage options will be allowed to change options.

Coverage begins on the first day of the plan year beginning on or after September 23, 2010, if we receive the completed enrollment form and any required Premium within 31 days of the date the Dependent becomes eligible to enroll under this special open enrollment period.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- [\[Registering a Domestic Partner.\]](#)

Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption, court or administrative order, or marriage will take effect on the date of the event. Coverage is effective only if

we receive any required Premium and are notified within 90 days of the birth, 60 days of the adoption or placement for adoption, or 31 days of the court or administrative order or marriage.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- [\[Registering a Domestic Partner.\]](#)

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period [\[or Open Enrollment Period\]](#) if the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period [\[or Open Enrollment Period\]](#); and
- Coverage under the prior plan ended because of any of the following:
 - Loss of eligibility (including legal separation, divorce or death).
 - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
 - In the case of COBRA continuation coverage, the coverage ended.
 - The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
 - The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
 - An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.
 - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event if we receive the completed enrollment form and 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.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period [or Open Enrollment Period] because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

[Include if group chooses to allow Late Enrollees to enroll and applies the Late Enrollee preexisting condition.]

[Late Enrollees]

[A Late Enrollee is an Eligible Person or Dependent who does not enroll for coverage under the Policy when he or she is first eligible, and who does not enroll during the Initial Enrollment Period [, Open Enrollment Period,] or a special enrollment period as described above.

Coverage for a Late Enrollee begins on the date agreed to by the Enrolling Group after we receive the completed enrollment form and any required Premium.]

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. *This does not apply if you are an inpatient in a Hospital on the date your coverage under the Policy would otherwise end as described under [Extended Coverage if You are Hospitalized](#).*

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). *[Please note that this does not affect coverage that is extended under [Extended Coverage for Total Disability](#) below.]*

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

[Please note that for Covered Persons who are subject to the [Extended Coverage for Total Disability](#) provision later in this section, entitlement to Benefits ends as described in that section.]

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

[Throughout this section, select appropriate option for "date" or "last day of the calendar month in which".]

- **You Are No Longer Eligible**

Your coverage ends on the [date][last day of the calendar month in which] you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for complete definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

Your coverage ends on the [date][last day of the calendar month in which] we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.

- **Subscriber Retires or Is Pensioned**

Your coverage ends the [date][last day of the calendar month in which] the Subscriber is retired or receiving benefits under the Enrolling Group's pension or retirement plan. The Enrolling Group is responsible for providing written notice to us to end your coverage.

This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is available for retirees.

Other Events Ending Your Coverage

When either of the following happens, we will provide advance written notice to the Subscriber that coverage will end on the date we identify in the notice:

- **Fraud or Intentional Misrepresentation of a Material Fact**

You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent.

During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

- **Threatening Behavior**

You committed acts of physical or verbal abuse that pose a threat to our staff.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask you to furnish us with proof of the medical certification of disability. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

Deleted: within 31 days of the date coverage would otherwise have ended because the child reached a certain age

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

[Extended Coverage for Total Disability]

[Coverage for a Covered Person who is Totally Disabled on the date the entire Policy is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- [Three - Eighteen] months from the date coverage would have ended when the entire Policy was terminated.]

Extended Coverage if You are Hospitalized

This provision is applicable only if the Policy terminates and is replaced by a group health insurance policy or contract issued by another insurer or by a self-funded health care plan. However, the extension of coverage does not apply if termination of the Policy occurs due to non-payment of Premium or fraud.

If you are an inpatient in a Hospital or other inpatient facility on the date your coverage under the Policy would otherwise terminate as described in the paragraph above, coverage will be extended until the earlier of:

The date your Inpatient Stay ends, or

The date you have exhausted the Inpatient Stay benefits under the Policy.

Continuation of Coverage and Conversion

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal [²⁻³or state] law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Enrolling Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Qualifying Events for Continuation Coverage under State Law

Coverage must have ended due to one of the following qualifying events:

- Termination of the Subscriber from employment with the Enrolling Group for any reason except gross misconduct.
- Termination of coverage due to loss of eligibility as a Subscriber or an Enrolled Dependent.

Notification Requirements and Election Period for Continuation Coverage under State Law

The Enrolling Group will provide you with written notification of the right to continuation coverage within days of when coverage ends under the Policy. You must elect continuation coverage within [] days of receiving this notification. You should obtain an election form from the Enrolling Group or the employer and, once election is made, forward all monthly Premiums to the Enrolling Group for payment to us.]

Terminating Events for Continuation Coverage under State Law

Continuation coverage under the Policy will end on the earliest of the following dates:

- 120 days from the date your continuation began.
- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date coverage is or could be obtained under any other group health plan.
- The date the Policy ends.

[³Continuation Coverage under State Law (Mini-COBRA)]

[³Continuation coverage under state law is available to you if you have been enrolled for coverage under the Policy for a continuous period of three months prior to the date coverage terminates and if your

coverage ends under the Policy as described below. This continuation applies to you if the Enrolling Group is an eligible small business with between 2-19 employees. Continuation coverage under state law is available to Enrolling Groups that are not subject to the terms of COBRA. You should call your Enrolling Group's plan administrator if you have questions about your right to continue coverage under state law.

Continuation coverage under state law is available for any of the following persons who was covered under the Policy on the day before a qualifying event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.

Continuation coverage is not available for any person who:

- Is covered or is eligible for coverage under Medicare.
- Fails to verify that he or she is ineligible for employer-based group health insurance as an eligible dependent.
- Is or could be covered by any other insured or uninsured arrangement which provides hospital, surgical or major medical coverage for individuals in a group.]

[³Qualifying Events for Continuation Coverage under State Law (Mini-COBRA)]

[³If coverage would ordinarily terminate due to one of the following qualifying events, then you are entitled to continue coverage. You are entitled to elect the same coverage that you had on the day before the qualifying event.

Qualifying events are:

- Termination of the Subscriber from employment with the Enrolling Group.
- Death of the Subscriber.
- Divorce or legal separation of the Subscriber.
- Loss of eligibility by an Enrolled Dependent who is a child.]

[³Notification Requirements and Election Period for Continuation Coverage under State Law (Mini-COBRA)]

[³The Enrolling Group's plan administrator must notify the Subscriber and us of a qualifying event within 30 days of the qualifying event. Notice to the Subscriber must include notices of the rights described in this section.

The Subscriber and/or Enrolled Dependent must notify the Enrolling Group's plan administrator of election of continuation coverage within 30 days of receiving notice as described above. You should obtain an election form from the Enrolling Group's plan administrator and, once election is made, forward any monthly premiums to the Enrolling Group for payment to us.]

[³Terminating Events for Continuation Coverage under State Law (Mini-COBRA)]

[³Continuation under the Policy will end on the earliest of the following dates:

- Nine months from the date of the qualifying event.
- The date coverage terminates under the Policy for failure to make timely payment of the Premium.

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you first become entitled to Medicare.
- The date the entire Policy ends.
- The date coverage would otherwise terminate under the Policy as described above under *Events Ending Your Coverage*.]

[¹Conversion]

[¹If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

Application and payment of the initial Premium must be made within 31 days after coverage ends under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.]

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, in our discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card. [\[When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:](#)

[\[Name of Pharmacy Benefit Manager\]](#)

[\[Address of Pharmacy Benefit Manager\]](#)

[\[City, State and Zip Code\]](#)

Payment of Benefits

[\[Applies when assignment of benefits is agreed to.\]](#)

[\[If a Subscriber provides written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber. But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.](#)

[Benefits will be paid to you unless either of the following is true:](#)

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.]

[Applies when assignment of benefits is not agreed to.]

[You may not assign your Benefits under the Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Subscriber) for you to reimburse them upon receipt of their bill. We may, however, in our discretion, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.]

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How to Appeal a Claim Decision

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

[Include if prior authorization includes determining alternate levels of benefits.]

Pre-service requests for Benefits are those requests that require prior authorization or benefit confirmation prior to receiving medical care. [\[If we adjust Eligible Expenses for identified Covered Health Services based on Generally Accepted Standards of Medical Practice, which for some Covered Health Services may be addressed in our clinical policies, you may appeal that decision pursuant to this process.\]](#)

How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Our decision is based on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Include when the state does not have the required external review process in place.

[Federal External Review Program]

[The *Departments of Health and Human Services, Labor and Treasury (Departments)* will establish a Federal external review process which will be available in those jurisdictions where no State external review process is in effect. Where applicable, once the process has been established by the *Departments*, we will provide you with additional information concerning the process.

Contact us at the telephone number shown on your ID card for more information on the Federal external review program.]

Include when the voluntary external review program applies.

[Voluntary External Review Program]

[After you exhaust the appeal process, if we make a final determination to deny Benefits, you may choose to participate in our voluntary external review program. This program only applies if our decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental or Investigational or Unproven Services.

The external review program is not available if our coverage determinations are based on Benefit exclusions or defined Benefit limits.

Contact us at the telephone number shown on your ID card for more information on the voluntary external review program.]

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

- A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.
- Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.
- B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

- D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
 2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
 3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
 5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.
- E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations

are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
 - 2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
 - b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
 - (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
 - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
 - (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the Custodial Parent.
 - (b) The Plan covering the Custodial Parent's spouse.
 - (c) The Plan covering the non-Custodial Parent.
 - (d) The Plan covering the non-Custodial Parent's spouse.

- c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

[Applies when plan design includes Medicare estimating.]

- [C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D].
- The person is enrolled in a *Medicare Advantage* (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D].

- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D] and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a *Medicare Medical Savings Account*. Medicare benefits are determined as if the person were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D].]

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Enrolling Group's Benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this *Certificate*.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of the termination of the Policy.

When the Enrolling Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers and Enrolling Groups

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Enrolling Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician.

These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. [\[We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.\]](#) [\[We pass these rebates on to you, and they are applied to any deductible and taken into account in determining your Copayments or Coinsurance.\]](#)

Interpretation of Benefits

We have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or

required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

[Applies when plan design includes Medicare estimating.]

[Medicare Eligibility]

[Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Policy.]

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under [both Medicare Part A and Part B] [Medicare Parts A, B and D] [Medicare Part D]. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in *Section 7: Coordination of Benefits*, we will pay Benefits under the Policy as if you were covered under [both Medicare Part A and Part B] [Medicare Parts A, B and D] [Medicare Part D]. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. You will

be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.]

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this *Certificate*, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
 - Providing any relevant information requested by us.
 - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or injuries.
 - Making court appearances.
 - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or

judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.

- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date

we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*, the Enrolling Group's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 9: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

[An Alternate Facility may also provide [Mental Health Services] [or] [Substance Use Disorder Services] on an outpatient or inpatient basis.]

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

[**Annual Maximum Benefit** - for Benefit plans that have an Annual Maximum Benefit, this is the maximum amount that we will pay for Benefits during the year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Annual Maximum Benefit and for details about how the Annual Maximum Benefit applies.]

[Applies when plan design includes benefits for infertility services.]

[Assisted Reproductive Technology (ART)] - the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).]

[Applies when plan design includes benefits for neurobiological disorder/autism spectrum disorder services.]

[Autism Spectrum Disorders] - a group of neurobiological disorders that includes *Autistic Disorder, Rhetts's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder* and *Pervasive Development Disorders Not Otherwise Specified (PDDNOS)*.]

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits* and any attached Riders and/or Amendments.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

[For Pharmaceutical Products, your Coinsurance is determined by the tier to which the *Pharmaceutical Product List Management Committee* has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

[Complications of Pregnancy - a condition that requires treatment during a Pregnancy or during the post-partum period.]

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

[Continuous Creditable Coverage - health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services and for their dependents.
- A medical care program of the *Indian Health Services Program* or a tribal organization.
- A state health benefits risk pool.
- *The Federal Employees Health Benefits Program*.
- *The State Children's Health Insurance Program (S-CHIP)*.
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the *Peace Corps Act*.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.]

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

[For Pharmaceutical Products, your Copayment is determined by the tier to which the *Pharmaceutical Product List Management Committee* has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this *Certificate* are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

[Options related to dependent eligibility are variable based upon the group's benefit plan eligibility rules.]

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. *[All references to the spouse of a Subscriber shall include a Domestic Partner.]* The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

[The definition of Dependent also includes parents [and grandparents] of the Subscriber [or the Subscriber's spouse] [or such other sponsored Dependents as agreed upon by us and the Enrolling Group].]

[To be eligible for coverage under the Policy, a Dependent must reside within the United States.]

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under [26 - 30] years of age.
- A Dependent includes an unmarried dependent child age [26 - 30] or older who is or becomes disabled and dependent upon the Subscriber.

[A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the date the child reaches age [26 - 30].]

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

[A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.]

[Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity.]

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Domestic Partner - a person of the [opposite sex] [same sex] [opposite or same sex] with whom the Subscriber has established a Domestic Partnership.]

Domestic Partnership - a relationship between a Subscriber and one other person of the [opposite sex] [same sex] [opposite or same sex]. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.

^[1]Applies if group requires documentation of financial interdependence.]

- They must be financially interdependent [^[1]and they have furnished documents to support at least two of the following conditions of such financial interdependence:
 - [They have a single dedicated relationship of at least [6 - 18] months duration.]
 - [They have joint ownership of a residence.]
 - [They have at least two of the following:
 - ◆ A joint ownership of an automobile.
 - ◆ A joint checking, bank or investment account.
 - ◆ A joint credit account.
 - ◆ A lease for a residence identifying both partners as tenants.
 - ◆ A will and/or life insurance policies which designates the other as primary beneficiary].]

^[2]Include if group requires signed affidavit.]

^[2]The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.]]

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.

- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. [\[An Eligible Person must reside within the United States.\]](#)

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or [\[Mental Illness\]](#)[\[mental illness\]](#) which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Enrolling Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.

- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Intensive Outpatient Treatment - a structured outpatient [mental health] [or] [substance use disorder] treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.]

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

[Late Enrollee - an Eligible Person or Dependent who enrolls for coverage under the Policy at a time other than the following:

- During the Initial Enrollment Period.
- During an Open Enrollment Period.
- During a special enrollment period as described in *Section 3: When Coverage Begins*.
- Within 31 days of the date a new Eligible Person first becomes eligible.]

- **Low Protein Modified Food Product** - a food product specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an Inherited Metabolic Disease under the direction of a Physician

[Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.]

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, [Mental Illness,] [mental illness,] substance use disorder, condition, disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, [Mental Illness,] [mental illness,] substance use disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

[Applies when plan design includes benefits for mental health services or neurobiological disorder/autism spectrum disorder services.]

[Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.]

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Mental Health/Substance Use Disorder Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.]

[Applies when plan design includes benefits for mental health services or neurobiological disorder/autism spectrum disorder services.]

[Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.]

[Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.]

[Applies when the Shared Savings Program is included. "Shared Savings Program" is bracketed to accommodate possible name change. This Shared Savings Program reference will not be included in a Choice COC.]

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services [by way of their participation in the [Shared Savings Program]]. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

[Applies when plan design does not include benefits for new pharmaceutical products.]

[New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product, for the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our Pharmaceutical Product List Management Committee.
- December 31st of the following calendar year.]

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

[Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.]

Orthotic Device - an external device that is, (i) intended to restore physiological function or cosmesis to a Covered Person; and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the Covered Person using the device prior to concurrent with the delivery of the device to the Covered Person.

Orthotic Service - the evaluation and treatment of a condition that requires the use of an Orthotic Device.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.]

[Per Occurrence Deductible - for Benefit plans that have a Per Occurrence Deductible, this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

When a Benefit plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of a Per Occurrence Deductible and for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.]

Pharmaceutical Product(s) - U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Pharmaceutical Product List - a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration (FDA). This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Pharmaceutical Product has been assigned through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Pharmaceutical Product List Management Committee - the committee that we designate for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy*.
- This *Certificate*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Enrolling Group.

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

[Preexisting Condition - an Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the [three] [six] month period ending on the person's

enrollment date. (The enrollment date is the date the person became covered under the Policy or, if earlier, the first day of any waiting period under the Policy.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.]

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

¹Applies when OB/GYN Physicians are considered Primary Physicians.]

²Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services and all clinicians are considered primary physicians.]

³Applies when clinicians providing psychological testing are not considered specialists.]

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, [¹obstetrics/gynecology,] family practice or general medicine. [²For [Mental Health Services] [and] [Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Primary Physician [³for the provision of all services other than psychological testing].]

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Prosthetic Device - an external device that is (i) intended to replace an external body part for the purpose of restoring physiological function or cosmesis to a patient; and (ii) custom designed, fabricated, assembled, fitted, or adjusted for patient using the device prior to or concurrent with being delivered to the Covered Person.

Prosthetic Service - the evaluation and treatment of a condition that requires the use of a Prosthetic Device.

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Residential Treatment Facility - a facility which provides a program of effective [Mental Health Services] [or] [Substance Use Disorder Services] treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.

- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.]

Rider - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

[Applies when the Shared Savings Program is included. "Shared Savings Program" is bracketed to accommodate possible name change. This Shared Savings Program reference will not be included in a Choice COC.]

[[Shared Savings Program] - the [Shared Savings Program] provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the [Shared Savings Program] to pay claims when doing so will lower Eligible Expenses. We do not credential the [Shared Savings Program] providers and the [Shared Savings Program] providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by [Shared Savings Program] providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the [Shared Savings 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 deductible.]

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* does not include [Mental Illness][mental illness] or substance use disorders, regardless of the cause or origin of the [Mental Illness][mental illness] or substance use disorder.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

¹*Applies when OB/GYN Physicians are considered Primary Physicians.]*

²*Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services and all clinicians are considered specialists.]*

³*Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services and only clinicians that perform psychological testing are considered specialists.]*

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, [¹obstetrics/gynecology,] family practice or general medicine. [²For [Mental Health Services] [and] [Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Specialist Physician.] [³For [Mental Health Services] [and] [Substance Use Disorder

Services], a licensed clinician who provides psychological testing is considered on the same basis as a Specialist Physician.]

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

[Applies when plan design includes benefits for substance use disorder services.]

[Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.]

[Applies when group purchases extended coverage for total disability.]

[Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.]

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Transitional Care - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

[Applies when plan design includes benefits for mental health services or neurobiological disorder/autism spectrum disorder services, but not substance use disorder services.]

[Transitional Care - Mental Health Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are supervised living arrangements which are residences that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence

available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.
- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
 - If the service is one that requires review by the *U.S. Food and Drug Administration (FDA)*, it must be *FDA*-approved.
 - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
 - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
 - At least two studies from more than one institution must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
 - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

SERFF Tracking Number: UHLC-126931158 State: Arkansas
 Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 47439
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: AR 2011 COC et. al
 Project Name/Number: /

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/03/2011	Form	COC	01/18/2011	AR 2011 COC Response 01.03.10.pdf (Superseded)
12/02/2010	Form	COC	01/03/2011	AR INS 2011 COC.pdf (Superseded)
01/03/2011	Supporting Document	COC Redline Document	01/18/2011	AR 2011 COC Redline 01.03.10.pdf (Superseded)

Certificate of Coverage

UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between [UnitedHealthcare Insurance Company](#) and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this *Certificate* the Policy includes:

- The *Group Policy*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document

We may from time to time modify this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When that happens we will send you a new *Certificate*, Rider or Amendment pages.

No one can make any changes to the Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of [\[State Name Here\]](#). The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of [\[State Name Here\]](#) are the laws that govern the Policy.

Introduction to Your Certificate

We are pleased to provide you with this *Certificate*. This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your *Certificate* and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 8: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this *Certificate* are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this *Certificate* and any summaries provided to you by the Enrolling Group, this *Certificate* will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*. You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

When we use the words "we," "us," and "our" in this document, we are referring to [UnitedHealthcare Insurance Company](#). When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your ID card. It will be our pleasure to assist you.

If we fail to provide you with reasonable and adequate service, you should feel free to contact the Arkansas Insurance Department at:

Arkansas Insurance Department
[Consumer Services Division]
[1200 West Third Street]
[Little Rock, AR 72201-1904]
[(800) 852-5494] or [(501) 371-2640]

Your Responsibilities

Be Enrolled and Pay Required Contributions

Benefits are available to you only if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled with us and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as a Subscriber or his or her Dependent as those terms are defined in *Section 9: Defined Terms*.

Your Enrolling Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy and receive Benefits. If you have questions about this, contact your Enrolling Group.

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

[Product Variables:]

[¹Choice Plus or Options PPO when network providers are responsible for prior authorization.]

[²Choice.]

[³Options PPO when network providers are not responsible for prior authorization or Non-Differential PPO when prior authorization is required for any service.]

Some Covered Health Services require prior authorization. [¹In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services.] [²In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services.] [³You are responsible for obtaining authorization before you receive the services.] For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Benefit plan's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Benefit plan for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in our discretion. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, in our sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this

prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider [by going to www.myuhc.com] or] by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

[Here and throughout the document, the defined term (capitalized) applies if Mental Health Benefits are sold, lower case reference applies if Mental Health Benefits are not sold.]

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 9: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, [\[Mental Illness,\]](#) [\[mental illness,\]](#) substance use disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Policy.
- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

[Bracketed plan features are plan design variable.]

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible, [\[Per Occurrence Deductible,\]](#) Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services [\[and any Annual Maximum Benefit\]](#)).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design. Include any other specific conditions for coverage described within the category.]

[1.] [Acupuncture Services]

[\[Acupuncture services for the following conditions:](#)

- [Pain therapy.](#)
- [Nausea that is related to surgery, Pregnancy or chemotherapy.](#)

[Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license \(if state license is available\) or who is certified by a national accrediting body:](#)

- [Doctor of Medicine.](#)
- [Doctor of Osteopathy.](#)

- [Chiropractor.](#)
- [Acupuncturist.\]](#)

[2.] Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

[3.] Clinical Trials

Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer.
- Cardiovascular disease (cardiac/stroke).
- Surgical musculoskeletal disorders of the spine, hip and knees.

[Include to support expanding clinical trial benefit to other diseases or disorders.]

- [\[Other diseases or disorders for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.\]](#)

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
 - Certain *Category B* devices.
 - Certain promising interventions for patients with terminal illnesses.
 - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be a qualifying clinical trial, a clinical trial must meet all of the following criteria:

- Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.
 - *Centers for Medicare and Medicaid Services (CMS)*.
 - *Department of Defense (DOD)*.
 - *Veterans Administration (VA)*.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

[4.] [Congenital Heart Disease Surgeries]

[Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

We have specific guidelines regarding Benefits for CHD services. Contact us at the telephone number on your ID card for information about these guidelines.]

[5.] [Dental Services - Accident Only]

[Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.]

[6.] Diabetes Services

Diabetes Self-Management Training is mandated in Arkansas.

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items

[Include paragraph below when group purchases the drug rider.]

[¹Include only when group purchases benefits for durable medical equipment.]

[Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. [¹An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment*.] Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider*.]

[Include paragraph and bulleted list below when group does not purchase the drug rider.]

[¹Include only when group does not purchase benefits for durable medical equipment.]

[²Include only when group purchases benefits for durable medical equipment.]

[Insulin pumps [¹that are not fully implanted into the body] and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including:

- [²Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment*.]
- Blood glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.]

[7.] [Durable Medical Equipment]

[Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

[Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.]

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

[Include when DME benefit is tiered and tiers are not to be included in COC.]

[To determine the Tiers to which Durable Medical Equipment are assigned, contact [www.myuhc.com] or *Customer Care* at the telephone number on your ID card.]

[Include when DME benefit is tiered and tiers are to be included in COC.]

[Durable Medical Equipment in Tier 1 is any item not specifically outlined in Tiers 2 or 3 below.

Durable Medical Equipment in Tier 2 is limited to the items listed below and any necessary supplies:

- Oxygen.
- Tube feeding pumps.
- Negative pressure wound therapy pumps (wound vacuums).
- Bi-level Positive Airway Pressure machines (BiPAPs).
- Bone growth stimulators.
- Pulse oximeters.
- Wearable automatic external defibrillators.
- Insulin pumps.
- Neuromuscular stimulators that we determine to be proven for use, and which are used as part of an approved rehabilitative program.
- [Speech aid devices and tracheo-esophageal voice devices.]

Durable Medical Equipment in Tier 3 is limited to the items listed below and any necessary supplies:

- Power wheel chairs.
- Ventilators.
- High frequency chest compression devices.
- Specialty beds for pressure reduction.]]

[8.] Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

[Include if plan design includes retrospective review of emergency services.]

[Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.]

Include as standard for groups of 2 to 15 and 15+.

[9.] Hearing Aids

[Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this *Certificate*, only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.]

[10.] Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

[11.] Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

[12.] Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

[13.] [Infertility Services]

[Services for the treatment of infertility when provided by or under the direction of a Physician, limited to the following procedures:

- Ovulation induction.
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Assisted Reproductive Technologies (ART).
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

To be eligible for Benefits, the Covered Person must meet all of the following:

- Have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35.
- Be under age 44, if female.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.]

[14.] Lab, X-Ray and Diagnostics - Outpatient

[Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office.]

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility *[or in a Physician's office]* include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

[Include when plan design supports paying the physician's office services benefit for Lab/X-ray performed in a physician's office.]

[When these services are performed in a Physician's office, Benefits are described under Physician's Office Services - Sickness and Injury.]

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient*.

[15.] Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

[Include when plan design has an office visit copayment and supports paying CT, PET, MRI, MRA and nuclear medicine benefit for services performed in a physician's office.]

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility *[or in a Physician's office]*.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.

- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[Include when plan design supports paying the physician's office services benefit for major diagnostics performed in a physician's office.]

[When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

[Include as standard for groups of 2 to 15]

[16.] [Mental Health Services]

[Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.]

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.]

[17.] [Neurobiological Disorders - Autism Spectrum Disorder Services]

[Psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.

- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available [¹under the applicable medical Covered Health Services categories in this *Certificate*] [²as described under [autism benefit section name] below].

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

[Include when expanded services for autism are required by state law. If there is not a state mandate requiring coverage ABA, delete this provision. It is not available for sale at a group specific level.]

[Note to contract specialist: This section should only be utilized to support the mental health component of state mandates for autism spectrum disorders for intensive behavioral therapies such as ABA. Delete this instruction prior to filing.]

[Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).]

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.]

[18.] [Obesity Surgery]

[Include the applicable criteria for coverage].

[Surgical treatment of obesity when provided by or under the direction of a Physician [when the Covered Person has a body mass index (BMI) greater than 40].

[Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met:

- [The Covered Person must have a body mass index (BMI) of greater than 40.]
- [The Covered Person must have a body mass index (BMI) of greater than 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by, obesity.]]

[19.] [Ostomy Supplies]

[Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.]

[20.] Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. [Benefits under this section do not include medications for the treatment of infertility.]

[Pharmaceutical Products are assigned to various tiers. The Pharmaceutical Product List Management Committee makes the final classification of a Pharmaceutical Product to a certain tier by considering a number of factors including clinical and economic factors. Clinical factors may include evaluations of the place in therapy, relative safety or relative efficacy of the Pharmaceutical Product, as well as whether prior authorization requirements should apply. Economic factors may include the Pharmaceutical Product's acquisition cost, including available rebates and assessments on the cost effectiveness of the Pharmaceutical Product.

Note: We may periodically change the placement of a Pharmaceutical Product among the tiers. These changes generally occur quarterly, but no more than six times per year. These changes may occur without prior notice to you. As a result of such changes, the tier status of a Pharmaceutical Product may change, and you may be required to pay more or less for that Pharmaceutical Product.

To determine the tiers to which Pharmaceutical Products are assigned, contact [www.myuhc.com] or *Customer Care* at the telephone number on your ID card. The amount that you are required to pay for Pharmaceutical Products will vary depending upon the tier to which the Pharmaceutical Product is assigned.]

[If you require certain Pharmaceutical Products[, including specialty Pharmaceutical Products,] we may direct you to a Designated Dispensing Entity with whom we have an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

[¹ Applies to Choice Plus and Options PPO products.]

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, [¹Network] Benefits are not available for that Pharmaceutical Product.]

[Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or prescription drug product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Benefits for certain Pharmaceutical Products are subject to the supply limits that are stated in the *Schedule of Benefits*. For a single Copayment and/or Coinsurance, you may receive Pharmaceutical Products up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per order or refill and/or the amount dispensed per month's supply.

You may determine whether a Pharmaceutical Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

[21.] Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

[22.] Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

[¹Include when Genetic Testing must be preceded by genetic counseling.]

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is [¹determined to be Medically Necessary following genetic counseling when] ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

[Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office. ²Include when only minor diagnostics are included under Physician's Office Services, but major diagnostics in a Physician's office are paid under the major diagnostic category.]

[Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. [²Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.]]

[Include when plan design supports paying Benefits for lab/X-ray only under the Lab/X-ray benefit.]

[When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.]

[¹Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude.]

^[2] If Maternity Services are excluded, Complications of Pregnancy must always be included.]

[23.] Pregnancy - ^[1]Maternity Services] ^[2]Complications of Pregnancy only]

^[1]Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.]

^[2]Benefits for Complications of Pregnancy include all Covered Health Services required for the non-obstetrical treatment of a condition related to a Complication of Pregnancy during a Pregnancy or during the post-partum period.

Both before and during a Pregnancy, Benefits are provided for the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We will pay Benefits for an Inpatient Stay of at least 96 hours for the mother and newborn child following a non-elective cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than this minimum time frame.]

[24.] Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Prosthetics are a mandated benefit in Arkansas.

[25.] Prosthetic Devices and Services

Benefits are available for the evaluation and treatment of a condition that requires the use of a prosthetic device. Benefits are available for external prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement when necessitated by anatomical change or normal use except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

[26.] Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]

[Short-term outpatient rehabilitation services, limited to:

- Physical therapy.
- Occupational therapy.
- [Manipulative Treatment.]
- Speech therapy.
- Pulmonary rehabilitation therapy.

- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.
- [Vision therapy.]

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. [Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.]

[Here and throughout the document, include defined capitalized term if plan design includes benefits for neurobiological disorder/autism spectrum disorder services. Include lower case reference if plan design does not include benefits for neurobiological disorder/autism spectrum disorder services.]

Please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or [autism spectrum disorders] [Autism Spectrum Disorders]. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.]

[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic

[Include when plan design has an office visit copayment and supports paying the scopic benefit for services performed in a physician's office.]

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility [or in a Physician's office].

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

[Include when plan design does not support paying the scopic procedures benefit for services performed in a physician's office.]

*[When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]*

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

[Include as standard for groups of 2 to 15]

[30.] Substance Use Disorder Services

[Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.]

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.]

[31.] Surgery - Outpatient

[¹Include when plan design has an office visit copayment and supports paying the outpatient surgery benefit for services performed in a physician's office.]

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility [¹or in a Physician's office].

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

[¹Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.]

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

[Include when plan design supports paying the physician's office services benefit for outpatient surgery performed in a physician's office.]

[When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

[32.] Temporomandibular Joint Services

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.

[33.] Therapeutic Treatments - Outpatient

[Include when plan design has an office visit copayment and supports paying the therapeutic treatments benefit for services performed in a physician's office.]

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility [\[or in a Physician's office\]](#), including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

[Include when plan design supports paying the physician's office services benefit for therapeutic treatments performed in a physician's office.]

*[When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]*

[34.] Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

[35.] Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

[36.] [Vision Examinations]

[\[Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office.\]](#)

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.]

[37.] [Wigs]

[Wigs and other scalp hair prosthesis regardless of the reason for hair loss.]

Additional Benefits Required By Arkansas Law

[38.] Dental Services - Anesthesia and Hospitalization

Covered Health Services for anesthesia and related hospital services in conjunction with a dental procedure, if the anesthesia and related hospital services are deemed medically necessary by the patient's Physician or dentist and the following conditions are met:

- The patient is a child age seven or younger who is diagnosed with a dental condition that requires certain dental procedures to be performed in a Hospital or Alternate Facility.
- The patient is diagnosed with a serious mental or physical condition or a significant behavioral problem as determined by the patient's Physician.

[39.] In Vitro Fertilization Services

Covered Health Services for in vitro fertilization services. Cryopreservation, the procedure whereby embryos are frozen for late implantation, will be included as an in vitro fertilization procedure. The coverage will include services performed at:

- A medical facility licensed or certified by the *Arkansas Department of Health*.
- A facility certified by the *Arkansas Department of Health* that conforms to the *American College of Obstetricians and Gynecologists* guidelines for in vitro fertilization clinics.
- A facility certified by the *Arkansas Department of Health* which meets the *American Fertility Society* minimal standards for programs of in vitro fertilization.

[40.] Medical Foods

Coverage for medical Foods and Low Protein Modified Food Products which are for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism and administered under the direction of a Physician is provided if the cost of the medical Foods and Low Protein Modified Food Products for an individual or a family with a Dependent person or persons exceeds the \$2,400 per year, per person income tax credit. If the cost of these products does not exceed the per person income tax credit, Benefits are not provided.

This is a mandated offer in Arkansas. If group chooses not to have this benefit, they must refuse this benefit in writing.

[[41.] Musculoskeletal Disorders of the Face, Neck or Head]

[Diagnosis and treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder, whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. Treatment will also include both surgical and non-surgical procedures. Coverage will be the same as that provided for any other musculoskeletal disorder in the body and will be provided whether prescribed or administered by a Physician or dentist.]

[[42.] Orthotic Devices and Services

Benefits are available for the evaluation and treatment of a condition that requires the use of an orthotic device.

Benefits are available for external orthotic devices that restore physiological function or cosmesis to you.

If more than one orthotic device can meet your functional needs, Benefits are available only for the orthotic device that meets the minimum specifications for your needs. If you purchase a orthotic device

that exceeds these minimum specifications, we will pay only the amount that we would have paid for the orthotic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The orthotic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement when necessitated by anatomical change or normal use except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen orthotic devices.

Orthotic devices do not include a cane, crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that:

- Is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and
- Has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

This exclusion does not apply to orthotics that are described under Orthotic Devices and Services in Section 1: Covered Health Services.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services* or through a Rider to the Policy.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

[Include bracketed variable exclusions below to support plan design. Unbracketed exclusions will always appear.]

A. Alternative Treatments

1. Acupressure [\[and acupuncture\]](#).
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolwing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to [\[Manipulative Treatment and\]](#) non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). [\[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.\]](#) [Dental Services - Anesthesia and Hospitalization](#) for which Benefits are provided as described in *Section 1: Covered Health Services*.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only in Section 1: Covered Health Services.*] *Dental Services - Anesthesia and Hospitalization* for which Benefits are provided as described in *Section 1: Covered Health Services.*

3. Dental implants, bone grafts and other implant-related procedures. [This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only in Section 1: Covered Health Services.*] *Dental Services - Anesthesia and Hospitalization* for which Benefits are provided as described in *Section 1: Covered Health Services.*
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. *This exclusion does not apply to orthotics as described under Durable Medical Equipment in Section 1: Covered Health Services.*
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses.
 - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech [except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment in Section 1: Covered Health Services.*]
6. Oral appliances for snoring.

[7.] Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.

[8.] Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.

[6.] [Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.]

[7.] [New Pharmaceutical Products and/or new dosage forms until the date they are assigned to a tier by our Pharmaceutical Product List Management Committee.]

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
 - Cleaning and soaking the feet.
 - Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

^[1]Applies when plan design does not include benefits for durable medical equipment.]

^[2]Applies when plan design includes benefits for durable medical equipment.]

G. Medical Supplies [¹and Equipment]

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:

- Compression stockings.
- Ace bandages.
- Gauze and dressings.
- Urinary catheters.
- [Ostomy supplies.]

This exclusion does not apply to:

- [²Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment in Section 1: Covered Health Services.*]
- Diabetic supplies for which Benefits are provided as described under *Diabetes Services in Section 1: Covered Health Services.*
- [Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies in Section 1: Covered Health Services.*]

2. Tubings and masks [²except when used with Durable Medical Equipment as described under *Durable Medical Equipment in Section 1: Covered Health Services.*]

[3.] [¹Medical equipment of any kind. This exclusion does not apply to insulin pumps for which Benefits are provided as described under *Diabetes Services in Section 1: Covered Health Services.*]

H. Mental Health

[Introductory sentence and exclusions 1-9 apply when plan design includes benefits for mental health services.]

[Exclusion 10 applies when plan design does not include benefits for mental health services. Renumber exclusion to #1.]

[Exclusions listed directly below apply to services described under *Mental Health Services in Section 1: Covered Health Services.*]

[1.] [Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*]

[2.] [Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*]

[3.] [Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.]

[4.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.]

[5.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.]

[6.] [Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act.*]

[7.] [Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*]

[8.] [Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.* Benefits

for autism spectrum disorder as a primary diagnosis are described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.]

- [9.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
 - Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.]

[¹Applies when the group provides benefits for mental health services under a separate plan.]

- [10.] [Services for the treatment of mental illness or mental health conditions [¹that the Enrolling Group has elected to provide through a separate benefit plan].]

I. Neurobiological Disorders - Autism Spectrum Disorders

[Introductory sentence and exclusions 1-8 apply when plan design includes benefits for neurobiological disorder/autism spectrum disorder services.]

[Exclusion 9 applies when plan design does not include benefits for neurobiological disorder/autism spectrum disorder services. Renumber exclusion to #1.]

[Exclusions listed directly below apply to services described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.]

- [1.] [Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]
- [2.] [Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.]
- [3.] [Mental retardation as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]
- [4.] [Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.]
- [5.] [Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.]
- [6.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.]

[Applies when plan design does not include benefits for expanded autism spectrum disorder.]

- [7.] [Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder.]
- [8.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.

- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.]

[Applies when plan design does not include benefits for neurobiological disorder/autism spectrum disorder services.]

[¹Applies when the group provides benefits for autism spectrum disorders under a separate plan.]

[9.] [Services for the treatment of autism spectrum disorders as the primary diagnosis [¹that the Enrolling Group has elected to provide through a separate benefit plan]. (Autism spectrum disorders are a group of neurobiological disorders that includes *Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder* and *Pervasive Development Disorders Not Otherwise Specified (PDDNOS).*)]

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
 - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
 - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
2. Enteral feedings, even if the sole source of nutrition. **This exclusion does not apply to medical foods for which Benefits are provided as described in *Section 1: Covered Health Services***
3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners, air purifiers and filters and dehumidifiers.
 - Batteries and battery chargers.
 - Breast pumps.
 - Car seats.
 - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
 - Exercise equipment.

- Home modifications such as elevators, handrails and ramps.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.

[5.] [Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.]

[6.] [Wigs regardless of the reason for the hair loss.]

[Applies when plan design does not provide benefits for pre-existing conditions.]

[M.] [Preexisting Conditions]

[A 12-month preexisting condition exclusion applies to all covered persons age 19 and older.]

[1.] [Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months. This exclusion does not apply to Covered Persons under age 19.]

[A 12-month preexisting condition exclusion applies to timely adds and an 18-month preexisting condition exclusion to late enrollees.]

[1.] [Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following:

- The date you have had Continuous Creditable Coverage for 12 months.
- The date you have had Continuous Creditable Coverage for 18 months if you are a Late Enrollee.

This exclusion does not apply to Covered Persons under age 19.]

[A preexisting condition exclusion applies to late enrollees only.]

[1.] [Benefits for the treatment of a Preexisting Condition are excluded for Late Enrollees until the date you have had Continuous Creditable Coverage for [12] [18] months. This exclusion does not apply to Covered Persons under age 19.]

[N.] Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

[Applies when plan design includes benefits for rehabilitation services.]

[4.] [Rehabilitation services [and Manipulative Treatment] to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.]

[Applies when plan design includes benefits for rehabilitation services.]

[5.] [Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or [autism spectrum disorders] [Autism Spectrum Disorders].]

[Applies when plan design includes benefits for rehabilitation services.]

[6.] [Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.]

[Applies when plan design does not include benefits for rehabilitation services.]

[5.] [Outpatient rehabilitation services. Examples include physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy, manipulative treatment, post-cochlear implant aural therapy, cognitive rehabilitation therapy and vision therapy.]

[6.] Psychosurgery.

- [7.] Sex transformation operations and related services.
- [8.] Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
- [9.] Biofeedback.

[Applies when plan design does not include benefits for manipulative treatment.]

- [10.] [Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function).]

[Applies when plan design does not include benefits for TMJ.]

- [11.] [Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.]

[Applies when plan design includes benefits for TMJ.]

- [11.] [The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.]

¹Include if group purchases optional benefit for Musculoskeletal Disorders.

- [12.] Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea. [¹This exclusion does not apply to Musculoskeletal Disorders of the Face, Neck or Head for which Benefits are provided as described in *Section 1: Covered Health Services under Additional Benefits Required By Arkansas Law.*]

- [13.] [Surgical and non-surgical treatment of obesity.] [Non-surgical treatment of obesity.] [Surgical treatment of obesity.]

- [14.] Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

[Applies when plan design does not include benefits for breast reduction.]

- [15.] [Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services.*]

[Applies when plan design includes benefits for breast reduction.]

- [16.] [Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services.*]

[Applies when plan design requires that implantation of ventricular assist devices be performed at a Designated Facility.]

- [17.] [Ventricular assist device implantation that is not performed at a Designated Facility. This exclusion does not apply to partial assist devices which are intended for short-term purposes or to Emergency implantations of partial assist devices.]

[Applies when plan design requires that Network Benefits for implantation of ventricular assist devices be performed at a Designated Facility.]

[18.] [Network Benefits for ventricular assist device implantation that is not performed at a Designated Facility. This exclusion does not apply to partial assist devices which are intended for short-term purposes or to Emergency implantations of partial assist devices.]

[O.] Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

- Has not been actively involved in your medical care prior to ordering the service, or
- Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography.

[P.] Reproduction

[Applies when plan design does not include benefits for infertility treatment.]

1. [Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. **except for In Vitro Fertilization Services for which Benefits are provided as described in Section 1: Covered Health Services.** This exclusion does not apply to services required to treat or correct underlying causes of infertility.]

[Applies when plan design includes benefits for infertility treatment.]

[The following infertility treatment-related services:

- Cryo-preservation and other forms of preservation of reproductive materials.
 - Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
 - Donor services.]
2. Surrogate parenting, donor eggs, donor sperm and host uterus.

[Applies when plan design does not include benefits for infertility treatment.]

3. [Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.]

[4.] The reversal of voluntary sterilization [and voluntary sterilization].

[5.] [Health services and associated expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).]

[6.] [Contraceptive supplies and services.]

[Will not apply when plan design includes benefits for infertility treatment.]

[7.] [Fetal reduction surgery.]

[Applies when plan design does not include full maternity benefits. This option is available only to groups with 14 or fewer employees.]

- [8.] [Maternity related medical services for prenatal care, postnatal care and delivery (other than a non-elective cesarean delivery).]
- [9.] [Maternity related medical services for Enrolled Dependent children.]

[Q.] Services Provided under another Plan

[Applies when plan design does not include benefits for 24 hour coverage.]

1. [Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or [Mental Illness] [mental illness] that would have been covered under workers' compensation or similar legislation had that coverage been elected.]

[Applies when plan design includes benefits for 24 hour coverage.]

- [Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes coverage required by workers' compensation, no-fault auto insurance, or similar legislation. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.]
2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

[R.] Substance Use Disorders

[Introductory sentence and exclusions 1-4 apply when plan design includes benefits for substance use disorder services.]

[Exclusion 5 applies when plan design does not include benefits for substance use disorder services. Renumber exclusion to #1.]

[Exclusions listed directly below apply to services described under *Substance Use Disorder Services* in *Section 1: Covered Health Services*.]

- [1.] [Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]
- [2.] [Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.]
- [3.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.]
- [4.] [Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.

- Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.]

[Applies when plan does not include benefits for substance use disorders.]

[¹Applies when the group provides benefits for substance use disorders under a separate plan.]

- [5.] [Services for the treatment of substance use disorder services [¹that the Enrolling Group has elected to provide through a separate benefit plan].]

[S.] Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.

[Applies to Network-only plans and to plans with Network and Non-Network benefits when Non-Network transplant benefits are not available and plan design requires transplants to take place at Designated Facilities.]

- [4.] [Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.]

[T.] Travel

1. [Health services provided in a foreign country, unless required as Emergency Health Services.]
- [2.] Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services*.

[U.] Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services*.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

[V.] Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses.

- [2.] [Routine vision examinations, including refractive examinations to determine the need for vision correction.]
- [3.] Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
- [4.] [Eye exercise or vision therapy.]
- [5.] Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.

[Applies when plan design provides benefits for hearing aids.]

- [6.] [Bone anchored hearing aids except when either of the following applies:
 - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
 - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy.

Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.]

[Applies when plan design does not provide benefits for hearing aids.]

- [6.] [Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.]

[W.] All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - ◆ Medically Necessary.
 - ◆ Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
 - ◆ Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
 - Required solely for purposes of school, sports or camp[, travel,] [career or employment,] insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.
 - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services.
11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins

How to Enroll

Eligible Persons must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the completed forms to us, along with any required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

[Applies when plan design includes Medicare estimating.]

[If You Are Eligible for Medicare]

[Your Benefits under the Policy may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under [both Medicare Part A and Part B] [Medicare Part A, Part B and Part D] [Medicare Part D].

Your Benefits under the Policy may also be reduced if you are enrolled in a Medicare Advantage (Medicare Part C) plan but fail to follow the rules of that plan. Please see Medicare Eligibility in Section 8: General Legal Provisions for more information about how Medicare may affect your Benefits.]

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Enrolling Group who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see *Section 9: Defined Terms*.

[Eligible Persons must reside within the United States.]

[If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.]

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

[If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.]

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Enrolling Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

[Applies when the Incentives for Health Rider is sold.]

[During this Initial Enrollment Period, the Enrolling Group will offer an incentive plan as described in the [Incentives for Health] Rider which is attached to this *Certificate*. In order to enroll in the [Incentives for Health] [in subsequent years] you must meet the eligibility requirements stated in the Rider.]

[Open Enrollment Period]

[The Enrolling Group determines the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.]

[Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.]

Dependent Child Special Open Enrollment Period

On or before the first day of the first plan year beginning on or after September 23, 2010, the Enrolling Group will provide a 30 day dependent child special open enrollment period for Dependent children who are not currently enrolled under the Policy and who have not yet reached the limiting age. During this dependent child special open enrollment period, Subscribers who are adding a Dependent child and who have a choice of coverage options will be allowed to change options.

Coverage begins on the first day of the plan year beginning on or after September 23, 2010, if we receive the completed enrollment form and any required Premium within 31 days of the date the Dependent becomes eligible to enroll under this special open enrollment period.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- [\[Registering a Domestic Partner.\]](#)

Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption, court or administrative order, or marriage will take effect on the date of the event. Coverage is effective only if

we receive any required Premium and are notified within 90 days of the birth, 60 days of the adoption or placement for adoption, or 31 days of the court or administrative order or marriage.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- [\[Registering a Domestic Partner.\]](#)

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period [\[or Open Enrollment Period\]](#) if the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period [\[or Open Enrollment Period\]](#); and
- Coverage under the prior plan ended because of any of the following:
 - Loss of eligibility (including legal separation, divorce or death).
 - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
 - In the case of COBRA continuation coverage, the coverage ended.
 - The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
 - The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
 - An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.
 - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event if we receive the completed enrollment form and 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.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period [or Open Enrollment Period] because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

[Include if group chooses to allow Late Enrollees to enroll and applies the Late Enrollee preexisting condition.]

[Late Enrollees]

[A Late Enrollee is an Eligible Person or Dependent who does not enroll for coverage under the Policy when he or she is first eligible, and who does not enroll during the Initial Enrollment Period [, Open Enrollment Period,] or a special enrollment period as described above.

Coverage for a Late Enrollee begins on the date agreed to by the Enrolling Group after we receive the completed enrollment form and any required Premium.]

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. **This does not apply if you are an inpatient in a Hospital on the date your coverage under the Policy would otherwise end as described under *Extended Coverage if You are Hospitalized*.**

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). **[Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.]**

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

[Please note that for Covered Persons who are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.]

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

[Throughout this section, select appropriate option for "date" or "last day of the calendar month in which".]

- **You Are No Longer Eligible**

Your coverage ends on the [date][last day of the calendar month in which] you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for complete definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

Your coverage ends on the [date][last day of the calendar month in which] we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.

- **Subscriber Retires or Is Pensioned**

Your coverage ends the [date][last day of the calendar month in which] the Subscriber is retired or receiving benefits under the Enrolling Group's pension or retirement plan. The Enrolling Group is responsible for providing written notice to us to end your coverage.

This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is available for retirees.

Other Events Ending Your Coverage

When either of the following happens, we will provide advance written notice to the Subscriber that coverage will end on the date we identify in the notice:

- **Fraud or Intentional Misrepresentation of a Material Fact**

You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent.

During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

- **Threatening Behavior**

You committed acts of physical or verbal abuse that pose a threat to our staff.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

[Extended Coverage for Total Disability]

[Coverage for a Covered Person who is Totally Disabled on the date the entire Policy is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- [Three - Eighteen] months from the date coverage would have ended when the entire Policy was terminated.]

Extended Coverage if You are Hospitalized

This provision is applicable only if the Policy terminates and is replaced by a group health insurance policy or contract issued by another insurer or by a self-funded health care plan. However, the extension of coverage does not apply if termination of the Policy occurs due to non-payment of Premium or fraud.

If you are an inpatient in a Hospital or other inpatient facility on the date your coverage under the Policy would otherwise terminate as described in the paragraph above, coverage will be extended until the earlier of:

The date your Inpatient Stay ends, or

The date you have exhausted the Inpatient Stay benefits under the Policy.

Continuation of Coverage and Conversion

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal [²⁻³or state] law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Enrolling Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Qualifying Events for Continuation Coverage under State Law

Coverage must have ended due to one of the following qualifying events:

- Termination of the Subscriber from employment with the Enrolling Group for any reason except gross misconduct.
- Termination of coverage due to loss of eligibility as a Subscriber or an Enrolled Dependent.

Notification Requirements and Election Period for Continuation Coverage under State Law

The Enrolling Group will provide you with written notification of the right to continuation coverage within days of when coverage ends under the Policy. You must elect continuation coverage within [__] days of receiving this notification. You should obtain an election form from the Enrolling Group or the employer and, once election is made, forward all monthly Premiums to the Enrolling Group for payment to us.]

Terminating Events for Continuation Coverage under State Law

Continuation coverage under the Policy will end on the earliest of the following dates:

- 120 days from the date your continuation began.
- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date coverage is or could be obtained under any other group health plan.
- The date the Policy ends.

[³Continuation Coverage under State Law (Mini-COBRA)]

[³Continuation coverage under state law is available to you if you have been enrolled for coverage under the Policy for a continuous period of three months prior to the date coverage terminates and if your coverage ends under the Policy as described below. This continuation applies to you if the Enrolling Group is an eligible small business with between 2-19 employees. Continuation coverage under state law is available to Enrolling Groups that are not subject to the terms of COBRA. You should call your Enrolling Group's plan administrator if you have questions about your right to continue coverage under state law.

Continuation coverage under state law is available for any of the following persons who was covered under the Policy on the day before a qualifying event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.

Continuation coverage is not available for any person who:

- Is covered or is eligible for coverage under Medicare.
- Fails to verify that he or she is ineligible for employer-based group health insurance as an eligible dependent.
- Is or could be covered by any other insured or uninsured arrangement which provides hospital, surgical or major medical coverage for individuals in a group.]

[³Qualifying Events for Continuation Coverage under State Law (Mini-COBRA)]

[³If coverage would ordinarily terminate due to one of the following qualifying events, then you are entitled to continue coverage. You are entitled to elect the same coverage that you had on the day before the qualifying event.

Qualifying events are:

- Termination of the Subscriber from employment with the Enrolling Group.
- Death of the Subscriber.
- Divorce or legal separation of the Subscriber.
- Loss of eligibility by an Enrolled Dependent who is a child.]

[³Notification Requirements and Election Period for Continuation Coverage under State Law (Mini-COBRA)]

[³The Enrolling Group's plan administrator must notify the Subscriber and us of a qualifying event within 30 days of the qualifying event. Notice to the Subscriber must include notices of the rights described in this section.

The Subscriber and/or Enrolled Dependent must notify the Enrolling Group's plan administrator of election of continuation coverage within 30 days of receiving notice as described above. You should obtain an election form from the Enrolling Group's plan administrator and, once election is made, forward any monthly premiums to the Enrolling Group for payment to us.]

[³Terminating Events for Continuation Coverage under State Law (Mini-COBRA)]

[³Continuation under the Policy will end on the earliest of the following dates:

- Nine months from the date of the qualifying event.
- The date coverage terminates under the Policy for failure to make timely payment of the Premium.
- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you first become entitled to Medicare.
- The date the entire Policy ends.
- The date coverage would otherwise terminate under the Policy as described above under *Events Ending Your Coverage.*]

[¹Conversion]

[¹If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

Application and payment of the initial Premium must be made within 31 days after coverage ends under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.]

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, in our discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card. [\[When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:](#)

[\[Name of Pharmacy Benefit Manager\]](#)

[\[Address of Pharmacy Benefit Manager\]](#)

[\[City, State and Zip Code\]](#)

Payment of Benefits

[\[Applies when assignment of benefits is agreed to.\]](#)

[\[If a Subscriber provides written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber. But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.](#)

[Benefits will be paid to you unless either of the following is true:](#)

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.]

[Applies when assignment of benefits is not agreed to.]

[You may not assign your Benefits under the Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Subscriber) for you to reimburse them upon receipt of their bill. We may, however, in our discretion, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.]

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How to Appeal a Claim Decision

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

[Include if prior authorization includes determining alternate levels of benefits.]

Pre-service requests for Benefits are those requests that require prior authorization or benefit confirmation prior to receiving medical care. [\[If we adjust Eligible Expenses for identified Covered Health Services based on Generally Accepted Standards of Medical Practice, which for some Covered Health Services may be addressed in our clinical policies, you may appeal that decision pursuant to this process.\]](#)

How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Our decision is based on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Include when the state does not have the required external review process in place.

[Federal External Review Program]

[The *Departments of Health and Human Services, Labor and Treasury (Departments)* will establish a Federal external review process which will be available in those jurisdictions where no State external review process is in effect. Where applicable, once the process has been established by the *Departments*, we will provide you with additional information concerning the process.

Contact us at the telephone number shown on your ID card for more information on the Federal external review program.]

Include when the voluntary external review program applies.

[Voluntary External Review Program]

[After you exhaust the appeal process, if we make a final determination to deny Benefits, you may choose to participate in our voluntary external review program. This program only applies if our decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental or Investigational or Unproven Services.

The external review program is not available if our coverage determinations are based on Benefit exclusions or defined Benefit limits.

Contact us at the telephone number shown on your ID card for more information on the voluntary external review program.]

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

- A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
 - 1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 - 2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

- D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
 2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
 3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
 5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.
- E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations

are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
 - 2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
 - b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
 - (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
 - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
 - (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the Custodial Parent.
 - (b) The Plan covering the Custodial Parent's spouse.
 - (c) The Plan covering the non-Custodial Parent.
 - (d) The Plan covering the non-Custodial Parent's spouse.

- c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

[Applies when plan design includes Medicare estimating.]

- C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D].
- The person is enrolled in a *Medicare Advantage* (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D].

- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D] and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a *Medicare Medical Savings Account*. Medicare benefits are determined as if the person were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D].]

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Enrolling Group's Benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this *Certificate*.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of the termination of the Policy.

When the Enrolling Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers and Enrolling Groups

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Enrolling Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician.

These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. [We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.] [We pass these rebates on to you, and they are applied to any deductible and taken into account in determining your Copayments or Coinsurance.]

Interpretation of Benefits

We have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or

required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

[Applies when plan design includes Medicare estimating.]

[Medicare Eligibility]

[Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Policy.]

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under [both Medicare Part A and Part B] [Medicare Parts A, B and D] [Medicare Part D]. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in *Section 7: Coordination of Benefits*, we will pay Benefits under the Policy as if you were covered under [both Medicare Part A and Part B] [Medicare Parts A, B and D] [Medicare Part D]. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. You will

be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.]

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this *Certificate*, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
 - Providing any relevant information requested by us.
 - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or injuries.
 - Making court appearances.
 - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or

judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.

- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date

we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*, the Enrolling Group's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 9: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

[An Alternate Facility may also provide [Mental Health Services] [or] [Substance Use Disorder Services] on an outpatient or inpatient basis.]

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

[**Annual Maximum Benefit** - for Benefit plans that have an Annual Maximum Benefit, this is the maximum amount that we will pay for Benefits during the year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Annual Maximum Benefit and for details about how the Annual Maximum Benefit applies.]

[Applies when plan design includes benefits for infertility services.]

[**Assisted Reproductive Technology (ART)** - the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).]

[Applies when plan design includes benefits for neurobiological disorder/autism spectrum disorder services.]

[**Autism Spectrum Disorders** - a group of neurobiological disorders that includes *Autistic Disorder, Rhetts Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder and Pervasive Development Disorders Not Otherwise Specified (PDDNOS)*.]

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits* and any attached Riders and/or Amendments.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

[For Pharmaceutical Products, your Coinsurance is determined by the tier to which the *Pharmaceutical Product List Management Committee* has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

[Complications of Pregnancy - a condition that requires treatment during a Pregnancy or during the post-partum period.]

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

[Continuous Creditable Coverage - health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services and for their dependents.
- A medical care program of the *Indian Health Services Program* or a tribal organization.
- A state health benefits risk pool.
- *The Federal Employees Health Benefits Program*.
- *The State Children's Health Insurance Program (S-CHIP)*.
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the *Peace Corps Act*.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.]

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

[For Pharmaceutical Products, your Copayment is determined by the tier to which the *Pharmaceutical Product List Management Committee* has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this *Certificate* are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

[Options related to dependent eligibility are variable based upon the group's benefit plan eligibility rules.]

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. *[All references to the spouse of a Subscriber shall include a Domestic Partner.]* The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

[The definition of Dependent also includes parents [and grandparents] of the Subscriber [or the Subscriber's spouse] [or such other sponsored Dependents as agreed upon by us and the Enrolling Group].]

[To be eligible for coverage under the Policy, a Dependent must reside within the United States.]

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under *[26 - 30]* years of age.
- A Dependent includes an unmarried dependent child age *[26 - 30]* or older who is or becomes disabled and dependent upon the Subscriber.

[A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the date the child reaches age [26 - 30].]

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

[A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.]

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity.]

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

[Domestic Partner - a person of the [opposite sex] [same sex] [opposite or same sex] with whom the Subscriber has established a Domestic Partnership.]

[Domestic Partnership - a relationship between a Subscriber and one other person of the [opposite sex] [same sex] [opposite or same sex]. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.

[¹Applies if group requires documentation of financial interdependence.]

- They must be financially interdependent [¹and they have furnished documents to support at least two of the following conditions of such financial interdependence:
 - [They have a single dedicated relationship of at least [6 - 18] months duration.]
 - [They have joint ownership of a residence.]
 - [They have at least two of the following:
 - ◆ A joint ownership of an automobile.
 - ◆ A joint checking, bank or investment account.
 - ◆ A joint credit account.
 - ◆ A lease for a residence identifying both partners as tenants.
 - ◆ A will and/or life insurance policies which designates the other as primary beneficiary].]

[²Include if group requires signed affidavit.]

[²The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.]

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.

- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. [\[An Eligible Person must reside within the United States.\]](#)

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or [\[Mental Illness\]](#)[\[mental illness\]](#) which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Enrolling Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.

- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Intensive Outpatient Treatment - a structured outpatient [mental health] [or] [substance use disorder] treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.]

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

[Late Enrollee - an Eligible Person or Dependent who enrolls for coverage under the Policy at a time other than the following:

- During the Initial Enrollment Period.
- During an Open Enrollment Period.
- During a special enrollment period as described in *Section 3: When Coverage Begins*.
- Within 31 days of the date a new Eligible Person first becomes eligible.]

- **Low Protein Modified Food Product** - a food product specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an Inherited Metabolic Disease under the direction of a Physician

[Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.]

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, **[Mental Illness,]** **[mental illness,]** substance use disorder, condition, disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, **[Mental Illness,]** **[mental illness,]** substance use disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

[Applies when plan design includes benefits for mental health services or neurobiological disorder/autism spectrum disorder services.]

[Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.]

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Mental Health/Substance Use Disorder Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.]

[Applies when plan design includes benefits for mental health services or neurobiological disorder/autism spectrum disorder services.]

[Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.]

[Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.]

[Applies when the Shared Savings Program is included. "Shared Savings Program" is bracketed to accommodate possible name change. This Shared Savings Program reference will not be included in a Choice COC.]

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services [\[by way of their participation in the \[Shared Savings Program\]\]](#). Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

[Applies when plan design does not include benefits for new pharmaceutical products.]

[New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product, for the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our Pharmaceutical Product List Management Committee.
- December 31st of the following calendar year.]

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

[Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.]

Orthotic Device - an external device that is, (i) intended to restore physiological function or cosmesis to a Covered Person; and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the Covered Person using the device prior to concurrent with the delivery of the device to the Covered Person.

Orthotic Service - the evaluation and treatment of a condition that requires the use of an Orthotic Device.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.]

[Per Occurrence Deductible - for Benefit plans that have a Per Occurrence Deductible, this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

When a Benefit plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of a Per Occurrence Deductible and for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.]

Pharmaceutical Product(s) - U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Pharmaceutical Product List - a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration (FDA). This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Pharmaceutical Product has been assigned through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Pharmaceutical Product List Management Committee - the committee that we designate for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy*.
- This *Certificate*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Enrolling Group.

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

[Preexisting Condition - an Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the [three] [six] month period ending on the person's

enrollment date. (The enrollment date is the date the person became covered under the Policy or, if earlier, the first day of any waiting period under the Policy.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.]

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

¹Applies when OB/GYN Physicians are considered Primary Physicians.]

²Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services and all clinicians are considered primary physicians.]

³Applies when clinicians providing psychological testing are not considered specialists.]

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, [¹obstetrics/gynecology,] family practice or general medicine. [²For [Mental Health Services] [and] [Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Primary Physician [³for the provision of all services other than psychological testing].]

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Prosthetic Device - an external device that is (i) intended to replace an external body part for the purpose of restoring physiological function or cosmesis to a patient; and (ii) custom designed, fabricated, assembled, fitted, or adjusted for patient using the device prior to or concurrent with being delivered to the Covered Person.

Prosthetic Service - the evaluation and treatment of a condition that requires the use of a Prosthetic Device.

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Residential Treatment Facility - a facility which provides a program of effective [Mental Health Services] [or] [Substance Use Disorder Services] treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.

- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.]

Rider - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

[Applies when the Shared Savings Program is included. "Shared Savings Program" is bracketed to accommodate possible name change. This Shared Savings Program reference will not be included in a Choice COC.]

[[Shared Savings Program] - the [Shared Savings Program] provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the [Shared Savings Program] to pay claims when doing so will lower Eligible Expenses. We do not credential the [Shared Savings Program] providers and the [Shared Savings Program] providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by [Shared Savings Program] providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the [Shared Savings 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 deductible.]

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* does not include [Mental Illness][mental illness] or substance use disorders, regardless of the cause or origin of the [Mental Illness][mental illness] or substance use disorder.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

[¹Applies when OB/GYN Physicians are considered Primary Physicians.]

[²Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services and all clinicians are considered specialists.]

[³Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services and only clinicians that perform psychological testing are considered specialists.]

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, [¹obstetrics/gynecology,] family practice or general medicine. [²For [Mental Health Services] [and] [Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Specialist Physician.] [³For [Mental Health Services] [and] [Substance Use Disorder

Services], a licensed clinician who provides psychological testing is considered on the same basis as a Specialist Physician.]

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

[Applies when plan design includes benefits for substance use disorder services.]

[Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.]

[Applies when group purchases extended coverage for total disability.]

[Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.]

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Transitional Care - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

[Applies when plan design includes benefits for mental health services or neurobiological disorder/autism spectrum disorder services, but not substance use disorder services.]

[Transitional Care - Mental Health Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are supervised living arrangements which are residences that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence

available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.
- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
 - If the service is one that requires review by the *U.S. Food and Drug Administration (FDA)*, it must be *FDA*-approved.
 - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
 - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
 - At least two studies from more than one institution must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
 - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Certificate of Coverage

UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between [UnitedHealthcare Insurance Company](#) and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this *Certificate* the Policy includes:

- The *Group Policy*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document

We may from time to time modify this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When that happens we will send you a new *Certificate*, Rider or Amendment pages.

No one can make any changes to the Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of [\[State Name Here\]](#). The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of [\[State Name Here\]](#) are the laws that govern the Policy.

Introduction to Your Certificate

We are pleased to provide you with this *Certificate*. This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your *Certificate* and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 8: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this *Certificate* are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this *Certificate* and any summaries provided to you by the Enrolling Group, this *Certificate* will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*. You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

When we use the words "we," "us," and "our" in this document, we are referring to [UnitedHealthcare Insurance Company](#). When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your ID card. It will be our pleasure to assist you.

If we fail to provide you with reasonable and adequate service, you should feel free to contact the Arkansas Insurance Department at:

Arkansas Insurance Department
[Consumer Services Division]
[1200 West Third Street]
[Little Rock, AR 72201-1904]
[(800) 852-5494] or [(501) 371-2640]

Your Responsibilities

Be Enrolled and Pay Required Contributions

Benefits are available to you only if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled with us and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as a Subscriber or his or her Dependent as those terms are defined in *Section 9: Defined Terms*.

Your Enrolling Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy and receive Benefits. If you have questions about this, contact your Enrolling Group.

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

[Product Variables:]

[¹Choice Plus or Options PPO when network providers are responsible for prior authorization.]

[²Choice.]

[³Options PPO when network providers are not responsible for prior authorization or Non-Differential PPO when prior authorization is required for any service.]

Some Covered Health Services require prior authorization. [¹In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services.] [²In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services.] [³You are responsible for obtaining authorization before you receive the services.] For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Benefit plan's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Benefit plan for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in our discretion. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, in our sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this

prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider [by going to www.myuhc.com] or] by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

[Here and throughout the document, the defined term (capitalized) applies if Mental Health Benefits are sold, lower case reference applies if Mental Health Benefits are not sold.]

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 9: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, *[Mental Illness,]* *[mental illness,]* substance use disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Policy.
- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

[Bracketed plan features are plan design variable.]

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible, *[Per Occurrence Deductible,]* Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services *[and any Annual Maximum Benefit]*).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design. Include any other specific conditions for coverage described within the category.]

[1.] [Acupuncture Services]

[Acupuncture services for the following conditions:

- Pain therapy.
- Nausea that is related to surgery, Pregnancy or chemotherapy.

Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.

- [Chiropractor.](#)
- [Acupuncturist.\]](#)

[2.] Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

[3.] Clinical Trials

Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer.
- Cardiovascular disease (cardiac/stroke).
- Surgical musculoskeletal disorders of the spine, hip and knees.

[Include to support expanding clinical trial benefit to other diseases or disorders.]

- [\[Other diseases or disorders for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.\]](#)

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
 - Certain *Category B* devices.
 - Certain promising interventions for patients with terminal illnesses.
 - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be a qualifying clinical trial, a clinical trial must meet all of the following criteria:

- Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.
 - *Centers for Medicare and Medicaid Services (CMS)*.
 - *Department of Defense (DOD)*.
 - *Veterans Administration (VA)*.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

[4.] [Congenital Heart Disease Surgeries]

[Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

We have specific guidelines regarding Benefits for CHD services. Contact us at the telephone number on your ID card for information about these guidelines.]

[5.] [Dental Services - Accident Only]

[Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.]

[6.] Diabetes Services

Diabetes Self-Management Training is mandated in Arkansas.

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items

[Include paragraph below when group purchases the drug rider.]

[¹Include only when group purchases benefits for durable medical equipment.]

[Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. [¹An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment*.] Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider*.]

[Include paragraph and bulleted list below when group does not purchase the drug rider.]

[¹Include only when group does not purchase benefits for durable medical equipment.]

[²Include only when group purchases benefits for durable medical equipment.]

[Insulin pumps [¹that are not fully implanted into the body] and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including:

- [²Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment*.]
- Blood glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.]

[7.] [Durable Medical Equipment]

[Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

[Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.]

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

[Include when DME benefit is tiered and tiers are not to be included in COC.]

[To determine the Tiers to which Durable Medical Equipment are assigned, contact [www.myuhc.com] or *Customer Care* at the telephone number on your ID card.]

[Include when DME benefit is tiered and tiers are to be included in COC.]

[Durable Medical Equipment in Tier 1 is any item not specifically outlined in Tiers 2 or 3 below.

Durable Medical Equipment in Tier 2 is limited to the items listed below and any necessary supplies:

- Oxygen.
- Tube feeding pumps.
- Negative pressure wound therapy pumps (wound vacuums).
- Bi-level Positive Airway Pressure machines (BiPAPs).
- Bone growth stimulators.
- Pulse oximeters.
- Wearable automatic external defibrillators.
- Insulin pumps.
- Neuromuscular stimulators that we determine to be proven for use, and which are used as part of an approved rehabilitative program.
- [Speech aid devices and tracheo-esophageal voice devices.]

Durable Medical Equipment in Tier 3 is limited to the items listed below and any necessary supplies:

- Power wheel chairs.
- Ventilators.
- High frequency chest compression devices.
- Specialty beds for pressure reduction.]]

[8.] Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

[Include if plan design includes retrospective review of emergency services.]

[Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.]

Include as standard for groups of 2 to 15 and 15+.

[9.] Hearing Aids

[Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this *Certificate*, only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.]

[10.] Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

[11.] Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

[12.] Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

[13.] [Infertility Services]

[Services for the treatment of infertility when provided by or under the direction of a Physician, limited to the following procedures:

- Ovulation induction.
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Assisted Reproductive Technologies (ART).
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

To be eligible for Benefits, the Covered Person must meet all of the following:

- Have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35.
- Be under age 44, if female.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.]

[14.] Lab, X-Ray and Diagnostics - Outpatient

[Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office.]

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility *[or in a Physician's office]* include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

[Include when plan design supports paying the physician's office services benefit for Lab/X-ray performed in a physician's office.]

[When these services are performed in a Physician's office, Benefits are described under Physician's Office Services - Sickness and Injury.]

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient*.

[15.] Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

[Include when plan design has an office visit copayment and supports paying CT, PET, MRI, MRA and nuclear medicine benefit for services performed in a physician's office.]

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility *[or in a Physician's office]*.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.

- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)]

[Include when plan design supports paying the physician's office services benefit for major diagnostics performed in a physician's office.]

[When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

[Include as standard for groups of 2 to 15]

[16.] [Mental Health Services]

[Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.]

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.]

[17.] [Neurobiological Disorders - Autism Spectrum Disorder Services]

[Psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.

- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available [¹under the applicable medical Covered Health Services categories in this *Certificate*] [²as described under [autism benefit section name] below].

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

[Include when expanded services for autism are required by state law. If there is not a state mandate requiring coverage ABA, delete this provision. It is not available for sale at a group specific level.]

[Note to contract specialist: This section should only be utilized to support the mental health component of state mandates for autism spectrum disorders for intensive behavioral therapies such as ABA. Delete this instruction prior to filing.]

[Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).]

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.]

[18.] [Obesity Surgery]

[Include the applicable criteria for coverage].

[Surgical treatment of obesity when provided by or under the direction of a Physician [when the Covered Person has a body mass index (BMI) greater than 40].

[Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met:

- [The Covered Person must have a body mass index (BMI) of greater than 40.]
- [The Covered Person must have a body mass index (BMI) of greater than 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by, obesity.]]

[19.] [Ostomy Supplies]

[Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.]

[20.] Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. [Benefits under this section do not include medications for the treatment of infertility.]

[Pharmaceutical Products are assigned to various tiers. The Pharmaceutical Product List Management Committee makes the final classification of a Pharmaceutical Product to a certain tier by considering a number of factors including clinical and economic factors. Clinical factors may include evaluations of the place in therapy, relative safety or relative efficacy of the Pharmaceutical Product, as well as whether prior authorization requirements should apply. Economic factors may include the Pharmaceutical Product's acquisition cost, including available rebates and assessments on the cost effectiveness of the Pharmaceutical Product.

Note: We may periodically change the placement of a Pharmaceutical Product among the tiers. These changes generally occur quarterly, but no more than six times per year. These changes may occur without prior notice to you. As a result of such changes, the tier status of a Pharmaceutical Product may change, and you may be required to pay more or less for that Pharmaceutical Product.

To determine the tiers to which Pharmaceutical Products are assigned, contact [www.myuhc.com] or *Customer Care* at the telephone number on your ID card. The amount that you are required to pay for Pharmaceutical Products will vary depending upon the tier to which the Pharmaceutical Product is assigned.]

[If you require certain Pharmaceutical Products[, including specialty Pharmaceutical Products,] we may direct you to a Designated Dispensing Entity with whom we have an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

[¹ Applies to Choice Plus and Options PPO products.]

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, [¹Network] Benefits are not available for that Pharmaceutical Product.]

[Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or prescription drug product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Benefits for certain Pharmaceutical Products are subject to the supply limits that are stated in the *Schedule of Benefits*. For a single Copayment and/or Coinsurance, you may receive Pharmaceutical Products up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per order or refill and/or the amount dispensed per month's supply.

You may determine whether a Pharmaceutical Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

[21.] Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

[22.] Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

[¹Include when Genetic Testing must be preceded by genetic counseling.]

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is [¹determined to be Medically Necessary following genetic counseling when] ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

[Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office. ²Include when only minor diagnostics are included under Physician's Office Services, but major diagnostics in a Physician's office are paid under the major diagnostic category.]

[Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. [²Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.]]

[Include when plan design supports paying Benefits for lab/X-ray only under the Lab/X-ray benefit.]

[When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.]

[¹Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude.]

^[2] If Maternity Services are excluded, Complications of Pregnancy must always be included.]

[23.] Pregnancy - [¹Maternity Services] [²Complications of Pregnancy only]

^[1]Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.]

^[2]Benefits for Complications of Pregnancy include all Covered Health Services required for the non-obstetrical treatment of a condition related to a Complication of Pregnancy during a Pregnancy or during the post-partum period.

Both before and during a Pregnancy, Benefits are provided for the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We will pay Benefits for an Inpatient Stay of at least 96 hours for the mother and newborn child following a non-elective cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than this minimum time frame.]

[24.] Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Prosthetics are a mandated benefit in Arkansas.

[25.] Prosthetic Devices and Services

Benefits are available for the evaluation and treatment of a condition that requires the use of a prosthetic device. Benefits are available for external prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement when necessitated by anatomical change or normal use except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

[26.] Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]

[Short-term outpatient rehabilitation services, limited to:

- Physical therapy.
- Occupational therapy.
- [Manipulative Treatment.]
- Speech therapy.
- Pulmonary rehabilitation therapy.

- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.
- [Vision therapy.]

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. [Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.]

[Here and throughout the document, include defined capitalized term if plan design includes benefits for neurobiological disorder/autism spectrum disorder services. Include lower case reference if plan design does not include benefits for neurobiological disorder/autism spectrum disorder services.]

Please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or [autism spectrum disorders] [Autism Spectrum Disorders]. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.]

[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic

[Include when plan design has an office visit copayment and supports paying the scopic benefit for services performed in a physician's office.]

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility [or in a Physician's office].

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

[Include when plan design does not support paying the scopic procedures benefit for services performed in a physician's office.]

*[When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]*

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

[Include as standard for groups of 2 to 15]

[30.] Substance Use Disorder Services

[Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.]

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.]

[31.] Surgery - Outpatient

[¹Include when plan design has an office visit copayment and supports paying the outpatient surgery benefit for services performed in a physician's office.]

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility [¹or in a Physician's office].

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

[¹Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.]

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

[Include when plan design supports paying the physician's office services benefit for outpatient surgery performed in a physician's office.]

[When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

[32.] Temporomandibular Joint Services

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.

[33.] Therapeutic Treatments - Outpatient

[Include when plan design has an office visit copayment and supports paying the therapeutic treatments benefit for services performed in a physician's office.]

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility [\[or in a Physician's office\]](#), including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

[Include when plan design supports paying the physician's office services benefit for therapeutic treatments performed in a physician's office.]

[When these services are performed in a Physician's office, Benefits are described under [Physician's Office Services - Sickness and Injury](#).]

[34.] Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

[35.] Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

[36.] [Vision Examinations]

[\[Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office.\]](#)

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.]

[37.] [Wigs]

[Wigs and other scalp hair prosthesis regardless of the reason for hair loss.]

Additional Benefits Required By Arkansas Law

[38.] Dental Services - Anesthesia and Hospitalization

Covered Health Services for anesthesia and related hospital services in conjunction with a dental procedure, if the anesthesia and related hospital services are deemed medically necessary by the patient's Physician or dentist and the following conditions are met:

- The patient is a child age seven or younger who is diagnosed with a dental condition that requires certain dental procedures to be performed in a Hospital or Alternate Facility.
- The patient is diagnosed with a serious mental or physical condition or a significant behavioral problem as determined by the patient's Physician.

[39.] In Vitro Fertilization Services

Covered Health Services for in vitro fertilization services. Cryopreservation, the procedure whereby embryos are frozen for later implantation, will be included as an in vitro fertilization procedure. The coverage will include services performed at:

- A medical facility licensed or certified by the *Arkansas Department of Health*.
- A facility certified by the *Arkansas Department of Health* that conforms to the *American College of Obstetricians and Gynecologists* guidelines for in vitro fertilization clinics.
- A facility certified by the *Arkansas Department of Health* which meets the *American Fertility Society* minimal standards for programs of in vitro fertilization.

[40.] Medical Foods

Coverage for medical Foods and Low Protein Modified Food Products which are for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism and administered under the direction of a Physician is provided if the cost of the medical Foods and Low Protein Modified Food Products for an individual or a family with a Dependent person or persons exceeds the \$2,400 per year, per person income tax credit. If the cost of these products does not exceed the per person income tax credit, Benefits are not provided.

This is a mandated offer in Arkansas. If group chooses not to have this benefit, they must refuse this benefit in writing.

[[41.] Musculoskeletal Disorders of the Face, Neck or Head]

[Diagnosis and treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder, whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. Treatment will also include both surgical and non-surgical procedures. Coverage will be the same as that provided for any other musculoskeletal disorder in the body and will be provided whether prescribed or administered by a Physician or dentist.]

[[42.] Orthotic Devices and Services

Benefits are available for the evaluation and treatment of a condition that requires the use of an orthotic device.

Benefits are available for external orthotic devices that restore physiological function or cosmesis to you.

If more than one orthotic device can meet your functional needs, Benefits are available only for the orthotic device that meets the minimum specifications for your needs. If you purchase a orthotic device

that exceeds these minimum specifications, we will pay only the amount that we would have paid for the orthotic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The orthotic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement when necessitated by anatomical change or normal use except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen orthotic devices.

Orthotic devices do not include a cane, crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that:

- Is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and
- Has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

This exclusion does not apply to orthotics that are described under Orthotic Devices and Services in Section 1: Covered Health Services.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services* or through a Rider to the Policy.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

[Include bracketed variable exclusions below to support plan design. Unbracketed exclusions will always appear.]

A. Alternative Treatments

1. Acupressure [\[and acupuncture\]](#).
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to [\[Manipulative Treatment and\]](#) non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). [\[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.\]](#) [Dental Services - Anesthesia and Hospitalization](#) for which Benefits are provided as described in *Section 1: Covered Health Services*.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only in Section 1: Covered Health Services.*] *Dental Services - Anesthesia and Hospitalization* for which Benefits are provided as described in *Section 1: Covered Health Services.*

3. Dental implants, bone grafts and other implant-related procedures. [This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only in Section 1: Covered Health Services.*] *Dental Services - Anesthesia and Hospitalization* for which Benefits are provided as described in *Section 1: Covered Health Services.*
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. *This exclusion does not apply to orthotics as described under Durable Medical Equipment in Section 1: Covered Health Services.*
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses.
 - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech [except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment in Section 1: Covered Health Services.*]
6. Oral appliances for snoring.

[7.] Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.

[8.] Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.

[6.] [Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.]

[7.] [New Pharmaceutical Products and/or new dosage forms until the date they are assigned to a tier by our Pharmaceutical Product List Management Committee.]

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
 - Cleaning and soaking the feet.
 - Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

^[1]Applies when plan design does not include benefits for durable medical equipment.]

^[2]Applies when plan design includes benefits for durable medical equipment.]

G. Medical Supplies [¹and Equipment]

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:

- Compression stockings.
- Ace bandages.
- Gauze and dressings.
- Urinary catheters.
- [Ostomy supplies.]

This exclusion does not apply to:

- [²Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment in Section 1: Covered Health Services.*]
- Diabetic supplies for which Benefits are provided as described under *Diabetes Services in Section 1: Covered Health Services.*
- [Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies in Section 1: Covered Health Services.*]

2. Tubings and masks [²except when used with Durable Medical Equipment as described under *Durable Medical Equipment in Section 1: Covered Health Services.*]

[3.] [¹Medical equipment of any kind. This exclusion does not apply to insulin pumps for which Benefits are provided as described under *Diabetes Services in Section 1: Covered Health Services.*]

H. Mental Health

[Introductory sentence and exclusions 1-9 apply when plan design includes benefits for mental health services.]

[Exclusion 10 applies when plan design does not include benefits for mental health services. Renumber exclusion to #1.]

[Exclusions listed directly below apply to services described under *Mental Health Services in Section 1: Covered Health Services.*]

- [1.] [Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*]
- [2.] [Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*]
- [3.] [Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.]
- [4.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.]
- [5.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.]
- [6.] [Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act.*]
- [7.] [Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*]
- [8.] [Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.* Benefits

for autism spectrum disorder as a primary diagnosis are described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.]

- [9.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
 - Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.]

[¹Applies when the group provides benefits for mental health services under a separate plan.]

- [10.] [Services for the treatment of mental illness or mental health conditions [¹that the Enrolling Group has elected to provide through a separate benefit plan].]

I. Neurobiological Disorders - Autism Spectrum Disorders

[Introductory sentence and exclusions 1-8 apply when plan design includes benefits for neurobiological disorder/autism spectrum disorder services.]

[Exclusion 9 applies when plan design does not include benefits for neurobiological disorder/autism spectrum disorder services. Renumber exclusion to #1.]

[Exclusions listed directly below apply to services described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.]

- [1.] [Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]
- [2.] [Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.]
- [3.] [Mental retardation as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]
- [4.] [Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.]
- [5.] [Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.]
- [6.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.]

[Applies when plan design does not include benefits for expanded autism spectrum disorder.]

- [7.] [Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder.]
- [8.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.

- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.]

[Applies when plan design does not include benefits for neurobiological disorder/autism spectrum disorder services.]

[¹Applies when the group provides benefits for autism spectrum disorders under a separate plan.]

[9.] [Services for the treatment of autism spectrum disorders as the primary diagnosis [¹that the Enrolling Group has elected to provide through a separate benefit plan]. (Autism spectrum disorders are a group of neurobiological disorders that includes *Autistic Disorder, Rhetts Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder* and *Pervasive Development Disorders Not Otherwise Specified (PDDNOS).*)]

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
 - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
 - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
2. Enteral feedings, even if the sole source of nutrition. **This exclusion does not apply to medical foods for which Benefits are provided as described in *Section 1: Covered Health Services***
3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners, air purifiers and filters and dehumidifiers.
 - Batteries and battery chargers.
 - Breast pumps.
 - Car seats.
 - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
 - Exercise equipment.

- Home modifications such as elevators, handrails and ramps.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.

[5.] [Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.]

[6.] [Wigs regardless of the reason for the hair loss.]

[Applies when plan design does not provide benefits for pre-existing conditions.]

[M.] [Preexisting Conditions]

[A 12-month preexisting condition exclusion applies to all covered persons age 19 and older.]

[1.] [Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months. This exclusion does not apply to Covered Persons under age 19.]

[A 12-month preexisting condition exclusion applies to timely adds and an 18-month preexisting condition exclusion to late enrollees.]

[1.] [Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following:

- The date you have had Continuous Creditable Coverage for 12 months.
- The date you have had Continuous Creditable Coverage for 18 months if you are a Late Enrollee.

This exclusion does not apply to Covered Persons under age 19.]

[A preexisting condition exclusion applies to late enrollees only.]

[1.] [Benefits for the treatment of a Preexisting Condition are excluded for Late Enrollees until the date you have had Continuous Creditable Coverage for [12] [18] months. This exclusion does not apply to Covered Persons under age 19.]

[N.] Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

[Applies when plan design includes benefits for rehabilitation services.]

[4.] [Rehabilitation services [and Manipulative Treatment] to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.]

[Applies when plan design includes benefits for rehabilitation services.]

[5.] [Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or [autism spectrum disorders] [Autism Spectrum Disorders].]

[Applies when plan design includes benefits for rehabilitation services.]

[6.] [Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.]

[Applies when plan design does not include benefits for rehabilitation services.]

[5.] [Outpatient rehabilitation services. Examples include physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy, manipulative treatment, post-cochlear implant aural therapy, cognitive rehabilitation therapy and vision therapy.]

[6.] Psychosurgery.

- [7.] Sex transformation operations and related services.
- [8.] Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
- [9.] Biofeedback.

[Applies when plan design does not include benefits for manipulative treatment.]

- [10.] [Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function).]

[Applies when plan design does not include benefits for TMJ.]

- [11.] [Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.]

[Applies when plan design includes benefits for TMJ.]

- [11.] [The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.]

¹Include if group purchases optional benefit for Musculoskeletal Disorders.

- [12.] Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea. [¹This exclusion does not apply to Musculoskeletal Disorders of the Face, Neck or Head for which Benefits are provided as described in *Section 1: Covered Health Services under Additional Benefits Required By Arkansas Law.*]

- [13.] [Surgical and non-surgical treatment of obesity.] [Non-surgical treatment of obesity.] [Surgical treatment of obesity.]

- [14.] Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

[Applies when plan design does not include benefits for breast reduction.]

- [15.] [Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services.*]

[Applies when plan design includes benefits for breast reduction.]

- [16.] [Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services.*]

[Applies when plan design requires that implantation of ventricular assist devices be performed at a Designated Facility.]

- [17.] [Ventricular assist device implantation that is not performed at a Designated Facility. This exclusion does not apply to partial assist devices which are intended for short-term purposes or to Emergency implantations of partial assist devices.]

[Applies when plan design requires that Network Benefits for implantation of ventricular assist devices be performed at a Designated Facility.]

[18.] [Network Benefits for ventricular assist device implantation that is not performed at a Designated Facility. This exclusion does not apply to partial assist devices which are intended for short-term purposes or to Emergency implantations of partial assist devices.]

[O.] Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

- Has not been actively involved in your medical care prior to ordering the service, or
- Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography.

[P.] Reproduction

[Applies when plan design does not include benefits for infertility treatment.]

1. [Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. **except for In Vitro Fertilization Services for which Benefits are provided as described in Section 1: Covered Health Services.** This exclusion does not apply to services required to treat or correct underlying causes of infertility.]

[Applies when plan design includes benefits for infertility treatment.]

[The following infertility treatment-related services:

- Cryo-preservation and other forms of preservation of reproductive materials.
 - Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
 - Donor services.]
2. Surrogate parenting, donor eggs, donor sperm and host uterus.

[Applies when plan design does not include benefits for infertility treatment.]

3. [Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.]

[4.] The reversal of voluntary sterilization [and voluntary sterilization].

[5.] [Health services and associated expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).]

[6.] [Contraceptive supplies and services.]

[Will not apply when plan design includes benefits for infertility treatment.]

[7.] [Fetal reduction surgery.]

[Applies when plan design does not include full maternity benefits. This option is available only to groups with 14 or fewer employees.]

- [8.] [Maternity related medical services for prenatal care, postnatal care and delivery (other than a non-elective cesarean delivery).]
- [9.] [Maternity related medical services for Enrolled Dependent children.]

[Q.] Services Provided under another Plan

[Applies when plan design does not include benefits for 24 hour coverage.]

1. [Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or [Mental Illness] [mental illness] that would have been covered under workers' compensation or similar legislation had that coverage been elected.]

[Applies when plan design includes benefits for 24 hour coverage.]

[Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes coverage required by workers' compensation, no-fault auto insurance, or similar legislation. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.]

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

[R.] Substance Use Disorders

[Introductory sentence and exclusions 1-4 apply when plan design includes benefits for substance use disorder services.]

[Exclusion 5 applies when plan design does not include benefits for substance use disorder services. Renumber exclusion to #1.]

[Exclusions listed directly below apply to services described under *Substance Use Disorder Services in Section 1: Covered Health Services.*]

- [1.] [Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*]
- [2.] [Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.]
- [3.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.]
- [4.] [Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.

- Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.]

[Applies when plan does not include benefits for substance use disorders.]

[¹Applies when the group provides benefits for substance use disorders under a separate plan.]

- [5.] [Services for the treatment of substance use disorder services [¹that the Enrolling Group has elected to provide through a separate benefit plan].]

[S.] Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.

[Applies to Network-only plans and to plans with Network and Non-Network benefits when Non-Network transplant benefits are not available and plan design requires transplants to take place at Designated Facilities.]

- [4.] [Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.]

[T.] Travel

1. [Health services provided in a foreign country, unless required as Emergency Health Services.]
- [2.] Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services*.

[U.] Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services*.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

[V.] Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses.

- [2.] [Routine vision examinations, including refractive examinations to determine the need for vision correction.]
- [3.] Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
- [4.] [Eye exercise or vision therapy.]
- [5.] Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.

[Applies when plan design provides benefits for hearing aids.]

- [6.] [Bone anchored hearing aids except when either of the following applies:
 - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
 - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy.

Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.]

[Applies when plan design does not provide benefits for hearing aids.]

- [6.] [Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.]

[W.] All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - ◆ Medically Necessary.
 - ◆ Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
 - ◆ Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
 - Required solely for purposes of school, sports or camp[, travel,] [career or employment,] insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.
 - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services.
11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins

How to Enroll

Eligible Persons must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the completed forms to us, along with any required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

[Applies when plan design includes Medicare estimating.]

[If You Are Eligible for Medicare]

[Your Benefits under the Policy may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under [both Medicare Part A and Part B] [Medicare Part A, Part B and Part D] [Medicare Part D].

Your Benefits under the Policy may also be reduced if you are enrolled in a Medicare Advantage (Medicare Part C) plan but fail to follow the rules of that plan. Please see Medicare Eligibility in Section 8: General Legal Provisions for more information about how Medicare may affect your Benefits.]

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Enrolling Group who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see *Section 9: Defined Terms*.

[Eligible Persons must reside within the United States.]

[If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.]

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

[If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.]

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Enrolling Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

[Applies when the Incentives for Health Rider is sold.]

[During this Initial Enrollment Period, the Enrolling Group will offer an incentive plan as described in the [Incentives for Health] Rider which is attached to this *Certificate*. In order to enroll in the [Incentives for Health] [in subsequent years] you must meet the eligibility requirements stated in the Rider.]

[Open Enrollment Period]

[The Enrolling Group determines the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.]

[Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.]

Dependent Child Special Open Enrollment Period

On or before the first day of the first plan year beginning on or after September 23, 2010, the Enrolling Group will provide a 30 day dependent child special open enrollment period for Dependent children who are not currently enrolled under the Policy and who have not yet reached the limiting age. During this dependent child special open enrollment period, Subscribers who are adding a Dependent child and who have a choice of coverage options will be allowed to change options.

Coverage begins on the first day of the plan year beginning on or after September 23, 2010, if we receive the completed enrollment form and any required Premium within 31 days of the date the Dependent becomes eligible to enroll under this special open enrollment period.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- [\[Registering a Domestic Partner.\]](#)

Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption, court or administrative order, or marriage will take effect on the date of the event. Coverage is effective only if

we receive any required Premium and are notified within 90 days of the birth, 60 days of the adoption or placement for adoption, or 31 days of the court or administrative order or marriage.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- [\[Registering a Domestic Partner.\]](#)

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period [\[or Open Enrollment Period\]](#) if the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period [\[or Open Enrollment Period\]](#); and
- Coverage under the prior plan ended because of any of the following:
 - Loss of eligibility (including legal separation, divorce or death).
 - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
 - In the case of COBRA continuation coverage, the coverage ended.
 - The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
 - The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
 - An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.
 - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event if we receive the completed enrollment form and 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.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period [or Open Enrollment Period] because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

[Include if group chooses to allow Late Enrollees to enroll and applies the Late Enrollee preexisting condition.]

[Late Enrollees]

[A Late Enrollee is an Eligible Person or Dependent who does not enroll for coverage under the Policy when he or she is first eligible, and who does not enroll during the Initial Enrollment Period [, Open Enrollment Period,] or a special enrollment period as described above.

Coverage for a Late Enrollee begins on the date agreed to by the Enrolling Group after we receive the completed enrollment form and any required Premium.]

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. **This does not apply if you are an inpatient in a Hospital on the date your coverage under the Policy would otherwise end as described under *Extended Coverage if You are Hospitalized*.**

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). **[Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.]**

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

[Please note that for Covered Persons who are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.]

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

[Throughout this section, select appropriate option for "date" or "last day of the calendar month in which".]

- **You Are No Longer Eligible**

Your coverage ends on the [date][last day of the calendar month in which] you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for complete definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

Your coverage ends on the [date][last day of the calendar month in which] we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.

- **Subscriber Retires or Is Pensioned**

Your coverage ends the [date][last day of the calendar month in which] the Subscriber is retired or receiving benefits under the Enrolling Group's pension or retirement plan. The Enrolling Group is responsible for providing written notice to us to end your coverage.

This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is available for retirees.

Other Events Ending Your Coverage

When either of the following happens, we will provide advance written notice to the Subscriber that coverage will end on the date we identify in the notice:

- **Fraud or Intentional Misrepresentation of a Material Fact**

You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent.

During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

- **Threatening Behavior**

You committed acts of physical or verbal abuse that pose a threat to our staff.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

[Extended Coverage for Total Disability]

[Coverage for a Covered Person who is Totally Disabled on the date the entire Policy is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- [Three - Eighteen] months from the date coverage would have ended when the entire Policy was terminated.]

Extended Coverage if You are Hospitalized

This provision is applicable only if the Policy terminates and is replaced by a group health insurance policy or contract issued by another insurer or by a self-funded health care plan. However, the extension of coverage does not apply if termination of the Policy occurs due to non-payment of Premium or fraud.

If you are an inpatient in a Hospital or other inpatient facility on the date your coverage under the Policy would otherwise terminate as described in the paragraph above, coverage will be extended until the earlier of:

The date your Inpatient Stay ends, or

The date you have exhausted the Inpatient Stay benefits under the Policy.

Continuation of Coverage and Conversion

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal [²⁻³or state] law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Enrolling Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Qualifying Events for Continuation Coverage under State Law

Coverage must have ended due to one of the following qualifying events:

- Termination of the Subscriber from employment with the Enrolling Group for any reason except gross misconduct.
- Termination of coverage due to loss of eligibility as a Subscriber or an Enrolled Dependent.

Notification Requirements and Election Period for Continuation Coverage under State Law

The Enrolling Group will provide you with written notification of the right to continuation coverage within days of when coverage ends under the Policy. You must elect continuation coverage within [] days of receiving this notification. You should obtain an election form from the Enrolling Group or the employer and, once election is made, forward all monthly Premiums to the Enrolling Group for payment to us.]

Terminating Events for Continuation Coverage under State Law

Continuation coverage under the Policy will end on the earliest of the following dates:

- 120 days from the date your continuation began.
- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date coverage is or could be obtained under any other group health plan.
- The date the Policy ends.

[³Continuation Coverage under State Law (Mini-COBRA)]

[³Continuation coverage under state law is available to you if you have been enrolled for coverage under the Policy for a continuous period of three months prior to the date coverage terminates and if your coverage ends under the Policy as described below. This continuation applies to you if the Enrolling Group is an eligible small business with between 2-19 employees. Continuation coverage under state law is available to Enrolling Groups that are not subject to the terms of COBRA. You should call your Enrolling Group's plan administrator if you have questions about your right to continue coverage under state law.

Continuation coverage under state law is available for any of the following persons who was covered under the Policy on the day before a qualifying event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.

Continuation coverage is not available for any person who:

- Is covered or is eligible for coverage under Medicare.
- Fails to verify that he or she is ineligible for employer-based group health insurance as an eligible dependent.
- Is or could be covered by any other insured or uninsured arrangement which provides hospital, surgical or major medical coverage for individuals in a group.]

[³Qualifying Events for Continuation Coverage under State Law (Mini-COBRA)]

[³If coverage would ordinarily terminate due to one of the following qualifying events, then you are entitled to continue coverage. You are entitled to elect the same coverage that you had on the day before the qualifying event.

Qualifying events are:

- Termination of the Subscriber from employment with the Enrolling Group.
- Death of the Subscriber.
- Divorce or legal separation of the Subscriber.
- Loss of eligibility by an Enrolled Dependent who is a child.]

[³Notification Requirements and Election Period for Continuation Coverage under State Law (Mini-COBRA)]

[³The Enrolling Group's plan administrator must notify the Subscriber and us of a qualifying event within 30 days of the qualifying event. Notice to the Subscriber must include notices of the rights described in this section.

The Subscriber and/or Enrolled Dependent must notify the Enrolling Group's plan administrator of election of continuation coverage within 30 days of receiving notice as described above. You should obtain an election form from the Enrolling Group's plan administrator and, once election is made, forward any monthly premiums to the Enrolling Group for payment to us.]

[³Terminating Events for Continuation Coverage under State Law (Mini-COBRA)]

[³Continuation under the Policy will end on the earliest of the following dates:

- Nine months from the date of the qualifying event.
- The date coverage terminates under the Policy for failure to make timely payment of the Premium.
- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you first become entitled to Medicare.
- The date the entire Policy ends.
- The date coverage would otherwise terminate under the Policy as described above under *Events Ending Your Coverage.*]

[¹Conversion]

[¹If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

Application and payment of the initial Premium must be made within 31 days after coverage ends under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.]

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, in our discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card. [\[When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:](#)

[\[Name of Pharmacy Benefit Manager\]](#)

[\[Address of Pharmacy Benefit Manager\]](#)

[\[City, State and Zip Code\]](#)

Payment of Benefits

[\[Applies when assignment of benefits is agreed to.\]](#)

[\[If a Subscriber provides written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber. But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.](#)

[Benefits will be paid to you unless either of the following is true:](#)

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.]

[Applies when assignment of benefits is not agreed to.]

[You may not assign your Benefits under the Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Subscriber) for you to reimburse them upon receipt of their bill. We may, however, in our discretion, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.]

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How to Appeal a Claim Decision

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

[Include if prior authorization includes determining alternate levels of benefits.]

Pre-service requests for Benefits are those requests that require prior authorization or benefit confirmation prior to receiving medical care. [\[If we adjust Eligible Expenses for identified Covered Health Services based on Generally Accepted Standards of Medical Practice, which for some Covered Health Services may be addressed in our clinical policies, you may appeal that decision pursuant to this process.\]](#)

How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Our decision is based on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Include when the state does not have the required external review process in place.

[Federal External Review Program]

[The *Departments of Health and Human Services, Labor and Treasury (Departments)* will establish a Federal external review process which will be available in those jurisdictions where no State external review process is in effect. Where applicable, once the process has been established by the *Departments*, we will provide you with additional information concerning the process.

Contact us at the telephone number shown on your ID card for more information on the Federal external review program.]

Include when the voluntary external review program applies.

[Voluntary External Review Program]

[After you exhaust the appeal process, if we make a final determination to deny Benefits, you may choose to participate in our voluntary external review program. This program only applies if our decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental or Investigational or Unproven Services.

The external review program is not available if our coverage determinations are based on Benefit exclusions or defined Benefit limits.

Contact us at the telephone number shown on your ID card for more information on the voluntary external review program.]

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

- A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
 - 1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 - 2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

- D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
 2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
 3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
 5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.
- E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations

are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
 - 2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
 - b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
 - (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
 - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
 - (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the Custodial Parent.
 - (b) The Plan covering the Custodial Parent's spouse.
 - (c) The Plan covering the non-Custodial Parent.
 - (d) The Plan covering the non-Custodial Parent's spouse.

- c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

[Applies when plan design includes Medicare estimating.]

- C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D].
- The person is enrolled in a *Medicare Advantage* (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D].

- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D] and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a *Medicare Medical Savings Account*. Medicare benefits are determined as if the person were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D].]

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Enrolling Group's Benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this *Certificate*.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of the termination of the Policy.

When the Enrolling Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers and Enrolling Groups

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Enrolling Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician.

These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. [\[We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.\]](#) [\[We pass these rebates on to you, and they are applied to any deductible and taken into account in determining your Copayments or Coinsurance.\]](#)

Interpretation of Benefits

We have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or

required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

[Applies when plan design includes Medicare estimating.]

[Medicare Eligibility]

[Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Policy.]

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under [both Medicare Part A and Part B] [Medicare Parts A, B and D] [Medicare Part D]. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in *Section 7: Coordination of Benefits*, we will pay Benefits under the Policy as if you were covered under [both Medicare Part A and Part B] [Medicare Parts A, B and D] [Medicare Part D]. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. You will

be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.]

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this *Certificate*, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
 - Providing any relevant information requested by us.
 - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or injuries.
 - Making court appearances.
 - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or

judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.

- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date

we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*, the Enrolling Group's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 9: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

[An Alternate Facility may also provide [Mental Health Services] [or] [Substance Use Disorder Services] on an outpatient or inpatient basis.]

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

[**Annual Maximum Benefit** - for Benefit plans that have an Annual Maximum Benefit, this is the maximum amount that we will pay for Benefits during the year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Annual Maximum Benefit and for details about how the Annual Maximum Benefit applies.]

[Applies when plan design includes benefits for infertility services.]

[**Assisted Reproductive Technology (ART)** - the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).]

[Applies when plan design includes benefits for neurobiological disorder/autism spectrum disorder services.]

[**Autism Spectrum Disorders** - a group of neurobiological disorders that includes *Autistic Disorder, Rhetts Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder and Pervasive Development Disorders Not Otherwise Specified (PDDNOS)*.]

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits* and any attached Riders and/or Amendments.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

[For Pharmaceutical Products, your Coinsurance is determined by the tier to which the *Pharmaceutical Product List Management Committee* has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

[Complications of Pregnancy - a condition that requires treatment during a Pregnancy or during the post-partum period.]

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

[Continuous Creditable Coverage - health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services and for their dependents.
- A medical care program of the *Indian Health Services Program* or a tribal organization.
- A state health benefits risk pool.
- *The Federal Employees Health Benefits Program*.
- *The State Children's Health Insurance Program (S-CHIP)*.
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the *Peace Corps Act*.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.]

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

[For Pharmaceutical Products, your Copayment is determined by the tier to which the *Pharmaceutical Product List Management Committee* has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this *Certificate* are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

[Options related to dependent eligibility are variable based upon the group's benefit plan eligibility rules.]

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. [\[All references to the spouse of a Subscriber shall include a Domestic Partner.\]](#) The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

[\[The definition of Dependent also includes parents \[and grandparents\] of the Subscriber \[or the Subscriber's spouse\] \[or such other sponsored Dependents as agreed upon by us and the Enrolling Group\].\]](#)

[\[To be eligible for coverage under the Policy, a Dependent must reside within the United States.\]](#)

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under [\[26 - 30\]](#) years of age.
- A Dependent includes an unmarried dependent child age [\[26 - 30\]](#) or older who is or becomes disabled and dependent upon the Subscriber.

[\[A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the date the child reaches age \[26 - 30\].\]](#)

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

[\[A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.\]](#)

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity.]

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

[Domestic Partner - a person of the [opposite sex] [same sex] [opposite or same sex] with whom the Subscriber has established a Domestic Partnership.]

[Domestic Partnership - a relationship between a Subscriber and one other person of the [opposite sex] [same sex] [opposite or same sex]. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.

^[1]Applies if group requires documentation of financial interdependence.

- They must be financially interdependent [¹and they have furnished documents to support at least two of the following conditions of such financial interdependence:
 - [They have a single dedicated relationship of at least [6 - 18] months duration.]
 - [They have joint ownership of a residence.]
 - [They have at least two of the following:
 - ◆ A joint ownership of an automobile.
 - ◆ A joint checking, bank or investment account.
 - ◆ A joint credit account.
 - ◆ A lease for a residence identifying both partners as tenants.
 - ◆ A will and/or life insurance policies which designates the other as primary beneficiary].]

^[2]Include if group requires signed affidavit.

^[2]The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.]

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.

- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. [\[An Eligible Person must reside within the United States.\]](#)

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or [\[Mental Illness\]](#)[\[mental illness\]](#) which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Enrolling Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.

- **Life-Threatening Sickness or Condition.** If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Intensive Outpatient Treatment - a structured outpatient [mental health] [or] [substance use disorder] treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.]

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

[Late Enrollee - an Eligible Person or Dependent who enrolls for coverage under the Policy at a time other than the following:

- During the Initial Enrollment Period.
- During an Open Enrollment Period.
- During a special enrollment period as described in *Section 3: When Coverage Begins*.
- Within 31 days of the date a new Eligible Person first becomes eligible.]

- **Low Protein Modified Food Product** - a food product specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an Inherited Metabolic Disease under the direction of a Physician

[Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.]

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, **[Mental Illness,]** **[mental illness,]** substance use disorder, condition, disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, **[Mental Illness,]** **[mental illness,]** substance use disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

[Applies when plan design includes benefits for mental health services or neurobiological disorder/autism spectrum disorder services.]

[Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.]

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Mental Health/Substance Use Disorder Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.]

[Applies when plan design includes benefits for mental health services or neurobiological disorder/autism spectrum disorder services.]

[Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.]

[Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.]

[Applies when the Shared Savings Program is included. "Shared Savings Program" is bracketed to accommodate possible name change. This Shared Savings Program reference will not be included in a Choice COC.]

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services [\[by way of their participation in the \[Shared Savings Program\]\]](#). Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

[Applies when plan design does not include benefits for new pharmaceutical products.]

[New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product, for the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our Pharmaceutical Product List Management Committee.
- December 31st of the following calendar year.]

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

[Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.]

Orthotic Device - an external device that is, (i) intended to restore physiological function or cosmesis to a Covered Person; and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the Covered Person using the device prior to concurrent with the delivery of the device to the Covered Person.

Orthotic Service - the evaluation and treatment of a condition that requires the use of an Orthotic Device.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Partial Hospitalization/Day Treatment] - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.]

[Per Occurrence Deductible] - for Benefit plans that have a Per Occurrence Deductible, this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

When a Benefit plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of a Per Occurrence Deductible and for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.]

Pharmaceutical Product(s) - U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Pharmaceutical Product List - a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration (FDA). This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Pharmaceutical Product has been assigned through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Pharmaceutical Product List Management Committee - the committee that we designate for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy*.
- This *Certificate*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Enrolling Group.

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

[Preexisting Condition] - an Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the [three] [six] month period ending on the person's

enrollment date. (The enrollment date is the date the person became covered under the Policy or, if earlier, the first day of any waiting period under the Policy.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.]

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

¹Applies when OB/GYN Physicians are considered Primary Physicians.]

²Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services and all clinicians are considered primary physicians.]

³Applies when clinicians providing psychological testing are not considered specialists.]

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, [¹obstetrics/gynecology,] family practice or general medicine. [²For [Mental Health Services] [and] [Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Primary Physician [³for the provision of all services other than psychological testing].]

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Prosthetic Device - an external device that is (i) intended to replace an external body part for the purpose of restoring physiological function or cosmesis to a patient; and (ii) custom designed, fabricated, assembled, fitted, or adjusted for patient using the device prior to or concurrent with being delivered to the Covered Person.

Prosthetic Service - the evaluation and treatment of a condition that requires the use of a Prosthetic Device.

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Residential Treatment Facility - a facility which provides a program of effective [Mental Health Services] [or] [Substance Use Disorder Services] treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.

- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.]

Rider - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

[Applies when the Shared Savings Program is included. "Shared Savings Program" is bracketed to accommodate possible name change. This Shared Savings Program reference will not be included in a Choice COC.]

[[Shared Savings Program] - the [Shared Savings Program] provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the [Shared Savings Program] to pay claims when doing so will lower Eligible Expenses. We do not credential the [Shared Savings Program] providers and the [Shared Savings Program] providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by [Shared Savings Program] providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the [Shared Savings 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 deductible.]

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* does not include [Mental Illness][mental illness] or substance use disorders, regardless of the cause or origin of the [Mental Illness][mental illness] or substance use disorder.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

[¹Applies when OB/GYN Physicians are considered Primary Physicians.]

[²Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services and all clinicians are considered specialists.]

[³Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services and only clinicians that perform psychological testing are considered specialists.]

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, [¹obstetrics/gynecology,] family practice or general medicine. [²For [Mental Health Services] [and] [Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Specialist Physician.] [³For [Mental Health Services] [and] [Substance Use Disorder

Services], a licensed clinician who provides psychological testing is considered on the same basis as a Specialist Physician.]

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

[Applies when plan design includes benefits for substance use disorder services.]

[Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.]

[Applies when group purchases extended coverage for total disability.]

[Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.]

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Transitional Care - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

[Applies when plan design includes benefits for mental health services or neurobiological disorder/autism spectrum disorder services, but not substance use disorder services.]

[Transitional Care - Mental Health Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are supervised living arrangements which are residences that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence

available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.
- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
 - If the service is one that requires review by the *U.S. Food and Drug Administration (FDA)*, it must be *FDA*-approved.
 - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
 - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
 - At least two studies from more than one institution must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
 - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Certificate of Coverage

UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between [UnitedHealthcare Insurance Company](#) and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this *Certificate* the Policy includes:

- The *Group Policy*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document

We may from time to time modify this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When that happens we will send you a new *Certificate*, Rider or Amendment pages.

No one can make any changes to the Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of [\[State Name Here\]](#). The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of [\[State Name Here\]](#) are the laws that govern the Policy.

Introduction to Your Certificate

We are pleased to provide you with this *Certificate*. This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your *Certificate* and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 8: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this *Certificate* are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this *Certificate* and any summaries provided to you by the Enrolling Group, this *Certificate* will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*. You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

When we use the words "we," "us," and "our" in this document, we are referring to [UnitedHealthcare Insurance Company](#). When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your ID card. It will be our pleasure to assist you.

If we fail to provide you with reasonable and adequate service, you should feel free to contact the Arkansas Insurance Department at:

Arkansas Insurance Department
[Consumer Services Division]
[1200 West Third Street]
[Little Rock, AR 72201-1904]
[(800) 852-5494] or [(501) 371-2640]

Your Responsibilities

Be Enrolled and Pay Required Contributions

Benefits are available to you only if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled with us and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as a Subscriber or his or her Dependent as those terms are defined in *Section 9: Defined Terms*.

Your Enrolling Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy and receive Benefits. If you have questions about this, contact your Enrolling Group.

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

[Product Variables:]

¹Choice Plus or Options PPO when network providers are responsible for prior authorization.]

²Choice.]

³Options PPO when network providers are not responsible for prior authorization or Non-Differential PPO when prior authorization is required for any service.]

Some Covered Health Services require prior authorization. *[¹In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services.] [²In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services.] [³You are responsible for obtaining authorization before you receive the services.]* For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Benefit plan's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Benefit plan for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in our discretion. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, in our sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this

prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider [\[by going to \[www.myuhc.com\] or\]](http://www.myuhc.com) by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

[Here and throughout the document, the defined term (capitalized) applies if Mental Health Benefits are sold, lower case reference applies if Mental Health Benefits are not sold.]

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 9: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, **[Mental Illness.] [mental illness.]** substance use disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Policy.
- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

[Bracketed plan features are plan design variable.]

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible, **[Per Occurrence Deductible.]** Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services **[and any Annual Maximum Benefit]**).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

[Include bracketed variable benefit categories below when the benefit is included in the plan design. Unbracketed benefit categories will always be included in plan design. Include any other specific conditions for coverage described within the category.]

[1.] [Acupuncture Services]

[Acupuncture services for the following conditions:

- Pain therapy.
- Nausea that is related to surgery, Pregnancy or chemotherapy.

Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.

- [Chiropractor.](#)
- [Acupuncturist.\]](#)

[2.] Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

[3.] Clinical Trials

Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer.
- Cardiovascular disease (cardiac/stroke).
- Surgical musculoskeletal disorders of the spine, hip and knees.

[Include to support expanding clinical trial benefit to other diseases or disorders.]

- [\[Other diseases or disorders for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.\]](#)

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
 - Certain *Category B* devices.
 - Certain promising interventions for patients with terminal illnesses.
 - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be a qualifying clinical trial, a clinical trial must meet all of the following criteria:

- Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.
 - *Centers for Medicare and Medicaid Services (CMS)*.
 - *Department of Defense (DOD)*.
 - *Veterans Administration (VA)*.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

[4.] [Congenital Heart Disease Surgeries]

[Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

We have specific guidelines regarding Benefits for CHD services. Contact us at the telephone number on your ID card for information about these guidelines.]

[5.] [Dental Services - Accident Only]

[Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.]

[6.] Diabetes Services

Diabetes Self-Management Training is mandated in Arkansas.

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items

[Include paragraph below when group purchases the drug rider.]

^[1]*Include only when group purchases benefits for durable medical equipment.]*

[Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. ^[1]An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment.*] Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider.*]

[Include paragraph and bulleted list below when group does not purchase the drug rider.]

^[1]*Include only when group does not purchase benefits for durable medical equipment.]*

^[2]*Include only when group purchases benefits for durable medical equipment.]*

[Insulin pumps ^[1]that are not fully implanted into the body] and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including:

- ^[2]Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment.*]
- Blood glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.]

[7.] [Durable Medical Equipment]

[Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

[Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.]

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

[Include when DME benefit is tiered and tiers are not to be included in COC.]

[To determine the Tiers to which Durable Medical Equipment are assigned, contact [www.myuhc.com] or Customer Care at the telephone number on your ID card.]

[Include when DME benefit is tiered and tiers are to be included in COC.]

[Durable Medical Equipment in Tier 1 is any item not specifically outlined in Tiers 2 or 3 below.

Durable Medical Equipment in Tier 2 is limited to the items listed below and any necessary supplies:

- Oxygen.
- Tube feeding pumps.
- Negative pressure wound therapy pumps (wound vacuums).
- Bi-level Positive Airway Pressure machines (BiPAPs).
- Bone growth stimulators.
- Pulse oximeters.
- Wearable automatic external defibrillators.
- Insulin pumps.
- Neuromuscular stimulators that we determine to be proven for use, and which are used as part of an approved rehabilitative program.
- [Speech aid devices and tracheo-esophageal voice devices.]

Durable Medical Equipment in Tier 3 is limited to the items listed below and any necessary supplies:

- Power wheel chairs.
- Ventilators.
- High frequency chest compression devices.
- Specialty beds for pressure reduction.]]

[8.] Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

[Include if plan design includes retrospective review of emergency services.]

[Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.]

Include as standard for groups of 2 to 15 and 15+.

[9.] Hearing Aids

[Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this *Certificate*, only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.]

[10.] Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

[11.] Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

[12.] Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

[13.] [Infertility Services]

[Services for the treatment of infertility when provided by or under the direction of a Physician, limited to the following procedures:

- Ovulation induction.
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Assisted Reproductive Technologies (ART).
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

To be eligible for Benefits, the Covered Person must meet all of the following:

- Have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35.
- Be under age 44, if female.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.]

[14.] Lab, X-Ray and Diagnostics - Outpatient

[Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office.]

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility *[or in a Physician's office]* include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

[Include when plan design supports paying the physician's office services benefit for Lab/X-ray performed in a physician's office.]

*[When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]*

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient*.

[15.] Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

[Include when plan design has an office visit copayment and supports paying CT, PET, MRI, MRA and nuclear medicine benefit for services performed in a physician's office.]

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility *[or in a Physician's office]*.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.

- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.*)

[Include when plan design supports paying the physician's office services benefit for major diagnostics performed in a physician's office.]

[When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury.*]

[Include as standard for groups of 2 to 15]

[16.] [Mental Health Services]

[Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.]

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.]

[17.] [Neurobiological Disorders - Autism Spectrum Disorder Services]

[Psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.

- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available [1 under the applicable medical Covered Health Services categories in this Certificate] [2 as described under [autism benefit section name] below].

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

[Include when expanded services for autism are required by state law. If there is not a state mandate requiring coverage ABA, delete this provision. It is not available for sale at a group specific level.]

[Note to contract specialist: This section should only be utilized to support the mental health component of state mandates for autism spectrum disorders for intensive behavioral therapies such as ABA. Delete this instruction prior to filing.]

[Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).]

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.]

[18.] [Obesity Surgery]

[Include the applicable criteria for coverage].

[Surgical treatment of obesity when provided by or under the direction of a Physician [when the Covered Person has a body mass index (BMI) greater than 40].

[Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met:

- [The Covered Person must have a body mass index (BMI) of greater than 40.]
- [The Covered Person must have a body mass index (BMI) of greater than 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by, obesity.]]

[19.] [Ostomy Supplies]

[Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.]

[20.] Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. [Benefits under this section do not include medications for the treatment of infertility.]

[Pharmaceutical Products are assigned to various tiers. The Pharmaceutical Product List Management Committee makes the final classification of a Pharmaceutical Product to a certain tier by considering a number of factors including clinical and economic factors. Clinical factors may include evaluations of the place in therapy, relative safety or relative efficacy of the Pharmaceutical Product, as well as whether prior authorization requirements should apply. Economic factors may include the Pharmaceutical Product's acquisition cost, including available rebates and assessments on the cost effectiveness of the Pharmaceutical Product.

Note: We may periodically change the placement of a Pharmaceutical Product among the tiers. These changes generally occur quarterly, but no more than six times per year. These changes may occur without prior notice to you. As a result of such changes, the tier status of a Pharmaceutical Product may change, and you may be required to pay more or less for that Pharmaceutical Product.

To determine the tiers to which Pharmaceutical Products are assigned, contact [www.myuhc.com] or *Customer Care* at the telephone number on your ID card. The amount that you are required to pay for Pharmaceutical Products will vary depending upon the tier to which the Pharmaceutical Product is assigned.]

[If you require certain Pharmaceutical Products[, including specialty Pharmaceutical Products,] we may direct you to a Designated Dispensing Entity with whom we have an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

[¹Applies to Choice Plus and Options PPO products.]

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, [¹Network] Benefits are not available for that Pharmaceutical Product.]

[Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or prescription drug product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

[Benefits for certain Pharmaceutical Products are subject to the supply limits that are stated in the *Schedule of Benefits*. For a single Copayment and/or Coinsurance, you may receive Pharmaceutical Products up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per order or refill and/or the amount dispensed per month's supply.

You may determine whether a Pharmaceutical Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.]

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

[21.] Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

[22.] Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

[¹Include when Genetic Testing must be preceded by genetic counseling.]

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is [¹determined to be Medically Necessary following genetic counseling when] ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

[Include when plan design has an office visit copayment and supports paying the Lab/X-ray benefit for services performed in a physician's office. ²Include when only minor diagnostics are included under Physician's Office Services, but major diagnostics in a Physician's office are paid under the major diagnostic category.]

[Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. [²Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.]]

[Include when plan design supports paying Benefits for lab/X-ray only under the Lab/X-ray benefit.]

[When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.]

[¹Always include Maternity Services benefit except when small groups (14 or fewer employees) choose to exclude.]

^[2]If Maternity Services are excluded, Complications of Pregnancy must always be included.]

[23.] Pregnancy - [¹Maternity Services] [²Complications of Pregnancy only]

^[1]Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.]

^[2]Benefits for Complications of Pregnancy include all Covered Health Services required for the non-obstetrical treatment of a condition related to a Complication of Pregnancy during a Pregnancy or during the post-partum period.

Both before and during a Pregnancy, Benefits are provided for the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We will pay Benefits for an Inpatient Stay of at least 96 hours for the mother and newborn child following a non-elective cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than this minimum time frame.]

[24.] Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Prosthetics are a mandated benefit in Arkansas.

[25.] Prosthetic Devices and Services

Benefits are available for the evaluation and treatment of a condition that requires the use of a prosthetic device. Benefits are available for external prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement when necessitated by anatomical change or normal use except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

[26.] Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

[27.] [Rehabilitation Services - Outpatient Therapy [and Manipulative Treatment]]

[Short-term outpatient rehabilitation services, limited to:

- Physical therapy.
- Occupational therapy.
- [Manipulative Treatment.]
- Speech therapy.
- Pulmonary rehabilitation therapy.

- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.
- [Vision therapy.]

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. [Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.]

[Here and throughout the document, include defined capitalized term if plan design includes benefits for neurobiological disorder/autism spectrum disorder services. Include lower case reference if plan design does not include benefits for neurobiological disorder/autism spectrum disorder services.]

Please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or [autism spectrum disorders] [Autism Spectrum Disorders]. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.]

[28.] Scopic Procedures - Outpatient Diagnostic and Therapeutic

[Include when plan design has an office visit copayment and supports paying the scopic benefit for services performed in a physician's office.]

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility [\[or in a Physician's office\]](#).

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

[Include when plan design does not support paying the scopic procedures benefit for services performed in a physician's office.]

[\[When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.\]](#)

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

[29.] Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

[Include as standard for groups of 2 to 15]

[30.] Substance Use Disorder Services

[Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.]

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.]

[31.] Surgery - Outpatient

[¹Include when plan design has an office visit copayment and supports paying the outpatient surgery benefit for services performed in a physician's office.]

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility [¹or in a Physician's office].

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

[¹Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.]

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

[Include when plan design supports paying the physician's office services benefit for outpatient surgery performed in a physician's office.]

[When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]

[32.] Temporomandibular Joint Services

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.

[33.] Therapeutic Treatments - Outpatient

[Include when plan design has an office visit copayment and supports paying the therapeutic treatments benefit for services performed in a physician's office.]

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility [\[or in a Physician's office\]](#), including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

[Include when plan design supports paying the physician's office services benefit for therapeutic treatments performed in a physician's office.]

*[When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.]*

[34.] Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

[35.] Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

[36.] [Vision Examinations]

[\[Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office.](#)

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.]

[37.] [Wigs]

[Wigs and other scalp hair prosthesis regardless of the reason for hair loss.]

Additional Benefits Required By Arkansas Law

[38.] Dental Services - Anesthesia and Hospitalization

Covered Health Services for anesthesia and related hospital services in conjunction with a dental procedure, if the anesthesia and related hospital services are deemed medically necessary by the patient's Physician or dentist and the following conditions are met:

- The patient is a child age seven or younger who is diagnosed with a dental condition that requires certain dental procedures to be performed in a Hospital or Alternate Facility.
- The patient is diagnosed with a serious mental or physical condition or a significant behavioral problem as determined by the patient's Physician.

[39.] In Vitro Fertilization Services

Covered Health Services for in vitro fertilization services. Cryopreservation, the procedure whereby embryos are frozen for late implantation, will be included as an in vitro fertilization procedure. The coverage will include services performed at:

- A medical facility licensed or certified by the *Arkansas Department of Health*.
- A facility certified by the *Arkansas Department of Health* that conforms to the *American College of Obstetricians and Gynecologists* guidelines for in vitro fertilization clinics.
- A facility certified by the *Arkansas Department of Health* which meets the *American Fertility Society* minimal standards for programs of in vitro fertilization.

[40.] Medical Foods

Coverage for medical Foods and Low Protein Modified Food Products which are for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism and administered under the direction of a Physician is provided if the cost of the medical Foods and Low Protein Modified Food Products for an individual or a family with a Dependent person or persons exceeds the \$2,400 per year, per person income tax credit. If the cost of these products does not exceed the per person income tax credit, Benefits are not provided.

This is a mandated offer in Arkansas. If group chooses not to have this benefit, they must refuse this benefit in writing.

[[41.] Musculoskeletal Disorders of the Face, Neck or Head]

[Diagnosis and treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder, whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. Treatment will also include both surgical and non-surgical procedures. Coverage will be the same as that provided for any other musculoskeletal disorder in the body and will be provided whether prescribed or administered by a Physician or dentist.]

[[42.] Orthotic Devices and Services

Benefits are available for the evaluation and treatment of a condition that requires the use of an orthotic device.

Benefits are available for external orthotic devices that restore physiological function or cosmesis to you.

If more than one orthotic device can meet your functional needs, Benefits are available only for the orthotic device that meets the minimum specifications for your needs. If you purchase a orthotic device

that exceeds these minimum specifications, we will pay only the amount that we would have paid for the orthotic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The orthotic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement when necessitated by anatomical change or normal use except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen orthotic devices.

Orthotic devices do not include a cane, crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that:

- Is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and
- Has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

This exclusion does not apply to orthotics that are described under Orthotic Devices and Services in Section 1: Covered Health Services.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services* or through a Rider to the Policy.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

[Include bracketed variable exclusions below to support plan design. Unbracketed exclusions will always appear.]

A. Alternative Treatments

1. Acupressure [\[and acupuncture\]](#).
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to [\[Manipulative Treatment and\]](#) non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). [\[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.\]](#) [Dental Services - Anesthesia and Hospitalization](#) for which Benefits are provided as described in *Section 1: Covered Health Services*.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

[This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only in Section 1: Covered Health Services.*] *Dental Services - Anesthesia and Hospitalization for which Benefits are provided as described in Section 1: Covered Health Services.*

3. Dental implants, bone grafts and other implant-related procedures. [This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only in Section 1: Covered Health Services.*] *Dental Services - Anesthesia and Hospitalization for which Benefits are provided as described in Section 1: Covered Health Services.*
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. *This exclusion does not apply to orthotics as described under Durable Medical Equipment in Section 1: Covered Health Services.*
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses.
 - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech [except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment in Section 1: Covered Health Services.*]
6. Oral appliances for snoring.

[7.] *Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.*

[8.] Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
 2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
 3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
 4. Over-the-counter drugs and treatments.
 5. Growth hormone therapy.
- [6.] [Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.]
- [7.] [New Pharmaceutical Products and/or new dosage forms until the date they are assigned to a tier by our Pharmaceutical Product List Management Committee.]

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
 2. Nail trimming, cutting, or debriding.
 3. Hygienic and preventive maintenance foot care. Examples include:
 - Cleaning and soaking the feet.
 - Applying skin creams in order to maintain skin tone.
- This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
 5. Treatment of subluxation of the foot.
 6. Shoes.
 7. Shoe orthotics.
 8. Shoe inserts.
 9. Arch supports.

^[1]Applies when plan design does not include benefits for durable medical equipment.]

^[2]Applies when plan design includes benefits for durable medical equipment.]

G. Medical Supplies [¹and Equipment]

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:

- Compression stockings.
- Ace bandages.
- Gauze and dressings.
- Urinary catheters.
- [Ostomy supplies.]

This exclusion does not apply to:

- [²Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.]
- Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
- [Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.]

2. Tubings and masks [²except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*].

[3.] [¹Medical equipment of any kind. This exclusion does not apply to insulin pumps for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.]

H. Mental Health

[Introductory sentence and exclusions 1-9 apply when plan design includes benefits for mental health services.]

[Exclusion 10 applies when plan design does not include benefits for mental health services. Renumber exclusion to #1.]

[Exclusions listed directly below apply to services described under *Mental Health Services* in *Section 1: Covered Health Services*.]

- [1.] [Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]
- [2.] [Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]
- [3.] [Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.]
- [4.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.]
- [5.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.]
- [6.] [Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.]
- [7.] [Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]
- [8.] [Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits

for autism spectrum disorder as a primary diagnosis are described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.]

- [9.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
 - Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.]

[¹Applies when the group provides benefits for mental health services under a separate plan.]

- [10.] [Services for the treatment of mental illness or mental health conditions [¹that the Enrolling Group has elected to provide through a separate benefit plan].]

I. Neurobiological Disorders - Autism Spectrum Disorders

[Introductory sentence and exclusions 1-8 apply when plan design includes benefits for neurobiological disorder/autism spectrum disorder services.]

[Exclusion 9 applies when plan design does not include benefits for neurobiological disorder/autism spectrum disorder services. Renumber exclusion to #1.]

[Exclusions listed directly below apply to services described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.]

- [1.] [Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]
- [2.] [Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.]
- [3.] [Mental retardation as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.]
- [4.] [Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.]
- [5.] [Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.]
- [6.] [Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.]

[Applies when plan design does not include benefits for expanded autism spectrum disorder.]

- [7.] [Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder.]
- [8.] [Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.

- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.]

[Applies when plan design does not include benefits for neurobiological disorder/autism spectrum disorder services.]

[¹Applies when the group provides benefits for autism spectrum disorders under a separate plan.]

[9.] [Services for the treatment of autism spectrum disorders as the primary diagnosis [¹that the Enrolling Group has elected to provide through a separate benefit plan]. (Autism spectrum disorders are a group of neurobiological disorders that includes *Autistic Disorder, Rhetts Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).*)]

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
 - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
 - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
2. Enteral feedings, even if the sole source of nutrition. **This exclusion does not apply to medical foods for which Benefits are provided as described in Section 1: Covered Health Services**
3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners, air purifiers and filters and dehumidifiers.
 - Batteries and battery chargers.
 - Breast pumps.
 - Car seats.
 - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
 - Exercise equipment.

- Home modifications such as elevators, handrails and ramps.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.

[5.] [Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.]

[6.] [Wigs regardless of the reason for the hair loss.]

[Applies when plan design does not provide benefits for pre-existing conditions.]

[M.] [Preexisting Conditions]

[A 12-month preexisting condition exclusion applies to all covered persons age 19 and older.]

[1.] [Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months. This exclusion does not apply to Covered Persons under age 19.]

[A 12-month preexisting condition exclusion applies to timely adds and an 18-month preexisting condition exclusion to late enrollees.]

[1.] [Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following:

- The date you have had Continuous Creditable Coverage for 12 months.
- The date you have had Continuous Creditable Coverage for 18 months if you are a Late Enrollee.

This exclusion does not apply to Covered Persons under age 19.]

[A preexisting condition exclusion applies to late enrollees only.]

[1.] [Benefits for the treatment of a Preexisting Condition are excluded for Late Enrollees until the date you have had Continuous Creditable Coverage for [12] [18] months. This exclusion does not apply to Covered Persons under age 19.]

[N.] Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

[Applies when plan design includes benefits for rehabilitation services.]

[4.] [Rehabilitation services [and Manipulative Treatment] to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.]

[Applies when plan design includes benefits for rehabilitation services.]

[5.] [Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or [autism spectrum disorders] [Autism Spectrum Disorders].]

[Applies when plan design includes benefits for rehabilitation services.]

[6.] [Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.]

[Applies when plan design does not include benefits for rehabilitation services.]

[5.] [Outpatient rehabilitation services. Examples include physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy, pulmonary rehabilitation therapy, manipulative treatment, post-cochlear implant aural therapy, cognitive rehabilitation therapy and vision therapy.]

[6.] Psychosurgery.

- [7.] Sex transformation operations and related services.
- [8.] Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
- [9.] Biofeedback.

[Applies when plan design does not include benefits for manipulative treatment.]

- [10.] [Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function).]

[Applies when plan design does not include benefits for TMJ.]

- [11.] [Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.]

[Applies when plan design includes benefits for TMJ.]

- [11.] [The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.]

¹Include if group purchases optional benefit for Musculoskeletal Disorders.

- [12.] Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury, dislocation, tumors or cancer. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea. [¹This exclusion does not apply to Musculoskeletal Disorders of the Face, Neck or Head for which Benefits are provided as described in Section 1: Covered Health Services under Additional Benefits Required By Arkansas Law.]

- [13.] [Surgical and non-surgical treatment of obesity.] [Non-surgical treatment of obesity.] [Surgical treatment of obesity.]

- [14.] Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

[Applies when plan design does not include benefits for breast reduction.]

- [15.] [Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1: Covered Health Services.]

[Applies when plan design includes benefits for breast reduction.]

- [16.] [Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which we determine is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1: Covered Health Services.]

[Applies when plan design requires that implantation of ventricular assist devices be performed at a Designated Facility.]

- [17.] [Ventricular assist device implantation that is not performed at a Designated Facility. This exclusion does not apply to partial assist devices which are intended for short-term purposes or to Emergency implantations of partial assist devices.]

[Applies when plan design requires that Network Benefits for implantation of ventricular assist devices be performed at a Designated Facility.]

[18.] [Network Benefits for ventricular assist device implantation that is not performed at a Designated Facility. This exclusion does not apply to partial assist devices which are intended for short-term purposes or to Emergency implantations of partial assist devices.]

[O.] Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
 - Has not been actively involved in your medical care prior to ordering the service, or
 - Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography.

[P.] Reproduction

[Applies when plan design does not include benefits for infertility treatment.]

1. [Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. except for In Vitro Fertilization Services for which Benefits are provided as described in Section 1: Covered Health Services. This exclusion does not apply to services required to treat or correct underlying causes of infertility.]

[Applies when plan design includes benefits for infertility treatment.]

[The following infertility treatment-related services:

- Cryo-preservation and other forms of preservation of reproductive materials.
 - Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
 - Donor services.]
2. Surrogate parenting, donor eggs, donor sperm and host uterus.

[Applies when plan design does not include benefits for infertility treatment.]

3. [Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.]

[4.] The reversal of voluntary sterilization [and voluntary sterilization].

[5.] [Health services and associated expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).]

[6.] [Contraceptive supplies and services.]

[Will not apply when plan design includes benefits for infertility treatment.]

[7.] [Fetal reduction surgery.]

[Applies when plan design does not include full maternity benefits. This option is available only to groups with 14 or fewer employees.]

[8.] [Maternity related medical services for prenatal care, postnatal care and delivery (other than a non-elective cesarean delivery).]

[9.] [Maternity related medical services for Enrolled Dependent children.]

[Q.] Services Provided under another Plan

[Applies when plan design does not include benefits for 24 hour coverage.]

1. [Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or [Mental Illness] [mental illness] that would have been covered under workers' compensation or similar legislation had that coverage been elected.]

[Applies when plan design includes benefits for 24 hour coverage.]

[Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes coverage required by workers' compensation, no-fault auto insurance, or similar legislation. This exclusion does not apply to Enrolling Groups that are not required by law to purchase or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.]

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

[R.] Substance Use Disorders

[Introductory sentence and exclusions 1-4 apply when plan design includes benefits for substance use disorder services.]

[Exclusion 5 applies when plan design does not include benefits for substance use disorder services. Renumber exclusion to #1.]

[Exclusions listed directly below apply to services described under *Substance Use Disorder Services in Section 1: Covered Health Services.*]

- [1.] [Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*]
- [2.] [Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.]
- [3.] [Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.]
- [4.] [Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.

- Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.]

[Applies when plan does not include benefits for substance use disorders.]

[¹Applies when the group provides benefits for substance use disorders under a separate plan.]

[5.] [Services for the treatment of substance use disorder services [¹that the Enrolling Group has elected to provide through a separate benefit plan].]

[S.] Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.

[Applies to Network-only plans and to plans with Network and Non-Network benefits when Non-Network transplant benefits are not available and plan design requires transplants to take place at Designated Facilities.]

[4.] [Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.]

[T.] Travel

1. [Health services provided in a foreign country, unless required as Emergency Health Services.]
- [2.] Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services*.

[U.] Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services*.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

[V.] Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses.

- [2.] [Routine vision examinations, including refractive examinations to determine the need for vision correction.]
- [3.] Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
- [4.] [Eye exercise or vision therapy.]
- [5.] Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.

[Applies when plan design provides benefits for hearing aids.]

- [6.] [Bone anchored hearing aids except when either of the following applies:
 - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
 - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy.

Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.]

[Applies when plan design does not provide benefits for hearing aids.]

- [6.] [Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.]

[W.] All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - ♦ Medically Necessary.
 - ♦ Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
 - ♦ Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
 - Required solely for purposes of school, sports or camp[, travel,] [career or employment,] insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.
 - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services.
11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins

How to Enroll

Eligible Persons must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the completed forms to us, along with any required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

[Applies when plan design includes Medicare estimating.]

[If You Are Eligible for Medicare]

[Your Benefits under the Policy may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under [both Medicare Part A and Part B] [Medicare Part A, Part B and Part D] [Medicare Part D].

Your Benefits under the Policy may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but fail to follow the rules of that plan. Please see *Medicare Eligibility* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.]

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Enrolling Group who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see *Section 9: Defined Terms*.

[Eligible Persons must reside within the United States.]

[If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.]

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

[If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.]

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Enrolling Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

[Applies when the Incentives for Health Rider is sold.]

[During this Initial Enrollment Period, the Enrolling Group will offer an incentive plan as described in the [Incentives for Health] Rider which is attached to this Certificate. In order to enroll in the [Incentives for Health] [in subsequent years] you must meet the eligibility requirements stated in the Rider.]

[Open Enrollment Period]

[The Enrolling Group determines the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.]

Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.]

Dependent Child Special Open Enrollment Period

On or before the first day of the first plan year beginning on or after September 23, 2010, the Enrolling Group will provide a 30 day dependent child special open enrollment period for Dependent children who are not currently enrolled under the Policy and who have not yet reached the limiting age. During this dependent child special open enrollment period, Subscribers who are adding a Dependent child and who have a choice of coverage options will be allowed to change options.

Coverage begins on the first day of the plan year beginning on or after September 23, 2010, if we receive the completed enrollment form and any required Premium within 31 days of the date the Dependent becomes eligible to enroll under this special open enrollment period.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- [\[Registering a Domestic Partner.\]](#)

Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption, court or administrative order, or marriage will take effect on the date of the event. Coverage is effective only if

we receive any required Premium and are notified within 90 days of the birth, 60 days of the adoption or placement for adoption, or 31 days of the court or administrative order or marriage.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- [\[Registering a Domestic Partner.\]](#)

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period [\[or Open Enrollment Period\]](#) if the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period [\[or Open Enrollment Period\]](#); and
- Coverage under the prior plan ended because of any of the following:
 - Loss of eligibility (including legal separation, divorce or death).
 - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
 - In the case of COBRA continuation coverage, the coverage ended.
 - The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
 - The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
 - An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.
 - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event if we receive the completed enrollment form and 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.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period [or Open Enrollment Period] because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

[Include if group chooses to allow Late Enrollees to enroll and applies the Late Enrollee preexisting condition.]

[Late Enrollees]

[A Late Enrollee is an Eligible Person or Dependent who does not enroll for coverage under the Policy when he or she is first eligible, and who does not enroll during the Initial Enrollment Period [, Open Enrollment Period,] or a special enrollment period as described above.

Coverage for a Late Enrollee begins on the date agreed to by the Enrolling Group after we receive the completed enrollment form and any required Premium.]

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. **This does not apply if you are an inpatient in a Hospital on the date your coverage under the Policy would otherwise end as described under *Extended Coverage if You are Hospitalized*.**

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). **[Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.]**

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

[Please note that for Covered Persons who are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.]

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

[Throughout this section, select appropriate option for "date" or "last day of the calendar month in which".]

- **You Are No Longer Eligible**

Your coverage ends on the [date][last day of the calendar month in which] you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for complete definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

Your coverage ends on the [date][last day of the calendar month in which] we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.

- **Subscriber Retires or Is Pensioned**

Your coverage ends the [date][last day of the calendar month in which] the Subscriber is retired or receiving benefits under the Enrolling Group's pension or retirement plan. The Enrolling Group is responsible for providing written notice to us to end your coverage.

This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is available for retirees.

Other Events Ending Your Coverage

When either of the following happens, we will provide advance written notice to the Subscriber that coverage will end on the date we identify in the notice:

- **Fraud or Intentional Misrepresentation of a Material Fact**

You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent.

During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

- **Threatening Behavior**

You committed acts of physical or verbal abuse that pose a threat to our staff.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

[Extended Coverage for Total Disability]

[Coverage for a Covered Person who is Totally Disabled on the date the entire Policy is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- [Three - Eighteen] months from the date coverage would have ended when the entire Policy was terminated.]

Deleted: If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.¶

Extended Coverage if You are Hospitalized

This provision is applicable only if the Policy terminates and is replaced by a group health insurance policy or contract issued by another insurer or by a self-funded health care plan. However, the extension of coverage does not apply if termination of the Policy occurs due to non-payment of Premium or fraud.

If you are an inpatient in a Hospital or other inpatient facility on the date your coverage under the Policy would otherwise terminate as described in the paragraph above, coverage will be extended until the earlier of:

The date your Inpatient Stay ends, or

The date you have exhausted the Inpatient Stay benefits under the Policy.

Continuation of Coverage and Conversion

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal [²⁻³or state] law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Enrolling Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Qualifying Events for Continuation Coverage under State Law

Coverage must have ended due to one of the following qualifying events:

- Termination of the Subscriber from employment with the Enrolling Group for any reason except gross misconduct.
- Termination of coverage due to loss of eligibility as a Subscriber or an Enrolled Dependent.

Notification Requirements and Election Period for Continuation Coverage under State Law

The Enrolling Group will provide you with written notification of the right to continuation coverage within days of when coverage ends under the Policy. You must elect continuation coverage within [] days of receiving this notification. You should obtain an election form from the Enrolling Group or the employer and, once election is made, forward all monthly Premiums to the Enrolling Group for payment to us.]

Terminating Events for Continuation Coverage under State Law

Continuation coverage under the Policy will end on the earliest of the following dates:

- 120 days from the date your continuation began.
- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date coverage is or could be obtained under any other group health plan.
- The date the Policy ends.

[³Continuation Coverage under State Law (Mini-COBRA)]

[³Continuation coverage under state law is available to you if you have been enrolled for coverage under the Policy for a continuous period of three months prior to the date coverage terminates and if your coverage ends under the Policy as described below. This continuation applies to you if the Enrolling Group is an eligible small business with between 2-19 employees. Continuation coverage under state law is available to Enrolling Groups that are not subject to the terms of COBRA. You should call your Enrolling Group's plan administrator if you have questions about your right to continue coverage under state law.

Continuation coverage under state law is available for any of the following persons who was covered under the Policy on the day before a qualifying event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.

Continuation coverage is not available for any person who:

- Is covered or is eligible for coverage under Medicare.
- Fails to verify that he or she is ineligible for employer-based group health insurance as an eligible dependent.
- Is or could be covered by any other insured or uninsured arrangement which provides hospital, surgical or major medical coverage for individuals in a group.]

[³Qualifying Events for Continuation Coverage under State Law (Mini-COBRA)]

[³If coverage would ordinarily terminate due to one of the following qualifying events, then you are entitled to continue coverage. You are entitled to elect the same coverage that you had on the day before the qualifying event.

Qualifying events are:

- Termination of the Subscriber from employment with the Enrolling Group.
- Death of the Subscriber.
- Divorce or legal separation of the Subscriber.
- Loss of eligibility by an Enrolled Dependent who is a child.]

[³Notification Requirements and Election Period for Continuation Coverage under State Law (Mini-COBRA)]

[³The Enrolling Group's plan administrator must notify the Subscriber and us of a qualifying event within 30 days of the qualifying event. Notice to the Subscriber must include notices of the rights described in this section.

The Subscriber and/or Enrolled Dependent must notify the Enrolling Group's plan administrator of election of continuation coverage within 30 days of receiving notice as described above. You should obtain an election form from the Enrolling Group's plan administrator and, once election is made, forward any monthly premiums to the Enrolling Group for payment to us.]

[³Terminating Events for Continuation Coverage under State Law (Mini-COBRA)]

[³Continuation under the Policy will end on the earliest of the following dates:

- Nine months from the date of the qualifying event.
- The date coverage terminates under the Policy for failure to make timely payment of the Premium.
- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you first become entitled to Medicare.
- The date the entire Policy ends.
- The date coverage would otherwise terminate under the Policy as described above under *Events Ending Your Coverage.*]

[¹Conversion]

[¹If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

Application and payment of the initial Premium must be made within 31 days after coverage ends under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.]

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, in our discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card. [\[When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:](#)

[\[Name of Pharmacy Benefit Manager\]](#)

[\[Address of Pharmacy Benefit Manager\]](#)

[\[City, State and Zip Code\]](#)

Payment of Benefits

[\[Applies when assignment of benefits is agreed to.\]](#)

[\[If a Subscriber provides written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber. But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.](#)

[Benefits will be paid to you unless either of the following is true:](#)

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.]

[Applies when assignment of benefits is not agreed to.]

[You may not assign your Benefits under the Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Subscriber) for you to reimburse them upon receipt of their bill. We may, however, in our discretion, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.]

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How to Appeal a Claim Decision

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

[Include if prior authorization includes determining alternate levels of benefits.]

Pre-service requests for Benefits are those requests that require prior authorization or benefit confirmation prior to receiving medical care. [\[If we adjust Eligible Expenses for identified Covered Health Services based on Generally Accepted Standards of Medical Practice, which for some Covered Health Services may be addressed in our clinical policies, you may appeal that decision pursuant to this process.\]](#)

How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Our decision is based on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Include when the state does not have the required external review process in place.

[Federal External Review Program]

[The *Departments of Health and Human Services, Labor and Treasury (Departments)* will establish a Federal external review process which will be available in those jurisdictions where no State external review process is in effect. Where applicable, once the process has been established by the *Departments*, we will provide you with additional information concerning the process.

Contact us at the telephone number shown on your ID card for more information on the Federal external review program.]

Include when the voluntary external review program applies.

[Voluntary External Review Program]

[After you exhaust the appeal process, if we make a final determination to deny Benefits, you may choose to participate in our voluntary external review program. This program only applies if our decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental or Investigational or Unproven Services.

The external review program is not available if our coverage determinations are based on Benefit exclusions or defined Benefit limits.

Contact us at the telephone number shown on your ID card for more information on the voluntary external review program.]

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

- A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
 - 1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 - 2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

- D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
 2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
 3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
 5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.
- E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations

are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
 - 2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
 - b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
 - (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
 - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
 - (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the Custodial Parent.
 - (b) The Plan covering the Custodial Parent's spouse.
 - (c) The Plan covering the non-Custodial Parent.
 - (d) The Plan covering the non-Custodial Parent's spouse.

- c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

[Applies when plan design includes Medicare estimating.]

- [C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D].
- The person is enrolled in a *Medicare Advantage* (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D].

- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D] and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a *Medicare Medical Savings Account*. Medicare benefits are determined as if the person were covered under Medicare [Parts A and B] [Parts A, B and D] [Part D].]

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Enrolling Group's Benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this *Certificate*.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of the termination of the Policy.

When the Enrolling Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers and Enrolling Groups

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Enrolling Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician.

These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. [\[We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.\]](#) [\[We pass these rebates on to you, and they are applied to any deductible and taken into account in determining your Copayments or Coinsurance.\]](#)

Interpretation of Benefits

We have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or

required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

[Applies when plan design includes Medicare estimating.]

[Medicare Eligibility]

[Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Policy.]

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under [both Medicare Part A and Part B] [Medicare Parts A, B and D] [Medicare Part D]. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in *Section 7: Coordination of Benefits*, we will pay Benefits under the Policy as if you were covered under [both Medicare Part A and Part B] [Medicare Parts A, B and D] [Medicare Part D]. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. You will

be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.]

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this *Certificate*, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
 - Providing any relevant information requested by us.
 - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or injuries.
 - Making court appearances.
 - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or

judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.

- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date

we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*, the Enrolling Group's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 9: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

[An Alternate Facility may also provide [Mental Health Services] [or] [Substance Use Disorder Services] on an outpatient or inpatient basis.]

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

[**Annual Maximum Benefit** - for Benefit plans that have an Annual Maximum Benefit, this is the maximum amount that we will pay for Benefits during the year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Annual Maximum Benefit and for details about how the Annual Maximum Benefit applies.]

[Applies when plan design includes benefits for infertility services.]

[Assisted Reproductive Technology (ART)] - the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).]

[Applies when plan design includes benefits for neurobiological disorder/autism spectrum disorder services.]

[Autism Spectrum Disorders] - a group of neurobiological disorders that includes *Autistic Disorder, Rhetts's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder* and *Pervasive Development Disorders Not Otherwise Specified (PDDNOS)*.]

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits* and any attached Riders and/or Amendments.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

[For Pharmaceutical Products, your Coinsurance is determined by the tier to which the *Pharmaceutical Product List Management Committee* has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

[Complications of Pregnancy - a condition that requires treatment during a Pregnancy or during the post-partum period.]

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

[Continuous Creditable Coverage - health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services and for their dependents.
- A medical care program of the *Indian Health Services Program* or a tribal organization.
- A state health benefits risk pool.
- *The Federal Employees Health Benefits Program*.
- *The State Children's Health Insurance Program (S-CHIP)*.
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the *Peace Corps Act*.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.]

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

[For Pharmaceutical Products, your Copayment is determined by the tier to which the *Pharmaceutical Product List Management Committee* has assigned the Pharmaceutical Product, and will vary based upon the tier assignment.]

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this *Certificate* are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

[Options related to dependent eligibility are variable based upon the group's benefit plan eligibility rules.]

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. *[All references to the spouse of a Subscriber shall include a Domestic Partner.]* The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

[The definition of Dependent also includes parents [and grandparents] of the Subscriber [or the Subscriber's spouse] [or such other sponsored Dependents as agreed upon by us and the Enrolling Group].]

[To be eligible for coverage under the Policy, a Dependent must reside within the United States.]

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under [26 - 30] years of age.
- A Dependent includes an unmarried dependent child age [26 - 30] or older who is or becomes disabled and dependent upon the Subscriber.

[A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the date the child reaches age [26 - 30].]

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

[A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.]

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity.]

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Domestic Partner - a person of the [opposite sex] [same sex] [opposite or same sex] with whom the Subscriber has established a Domestic Partnership.]

Domestic Partnership - a relationship between a Subscriber and one other person of the [opposite sex] [same sex] [opposite or same sex]. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.

^[1]Applies if group requires documentation of financial interdependence.]

- They must be financially interdependent [^[1]and they have furnished documents to support at least two of the following conditions of such financial interdependence:
 - [They have a single dedicated relationship of at least [6 - 18] months duration.]
 - [They have joint ownership of a residence.]
 - [They have at least two of the following:
 - ◆ A joint ownership of an automobile.
 - ◆ A joint checking, bank or investment account.
 - ◆ A joint credit account.
 - ◆ A lease for a residence identifying both partners as tenants.
 - ◆ A will and/or life insurance policies which designates the other as primary beneficiary].]

^[2]Include if group requires signed affidavit.]

^[2]The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.]]

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.

- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. [\[An Eligible Person must reside within the United States.\]](#)

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or [\[Mental Illness\]](#)[\[mental illness\]](#) which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Enrolling Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.

- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Intensive Outpatient Treatment - a structured outpatient [mental health] [or] [substance use disorder] treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.]

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

[Late Enrollee - an Eligible Person or Dependent who enrolls for coverage under the Policy at a time other than the following:

- During the Initial Enrollment Period.
- During an Open Enrollment Period.
- During a special enrollment period as described in *Section 3: When Coverage Begins*.
- Within 31 days of the date a new Eligible Person first becomes eligible.]

- **Low Protein Modified Food Product** - a food product specifically formulated to have less than one gram of protein per serving and intended for the dietary treatment of an Inherited Metabolic Disease under the direction of a Physician

[Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.]

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, [Mental Illness,] [mental illness,] substance use disorder, condition, disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, [Mental Illness,] [mental illness,] substance use disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

[Applies when plan design includes benefits for mental health services or neurobiological disorder/autism spectrum disorder services.]

[Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.]

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Mental Health/Substance Use Disorder Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.]

[Applies when plan design includes benefits for mental health services or neurobiological disorder/autism spectrum disorder services.]

[Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.]

[Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.]

[Applies when the Shared Savings Program is included. "Shared Savings Program" is bracketed to accommodate possible name change. This Shared Savings Program reference will not be included in a Choice COC.]

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services [by way of their participation in the [Shared Savings Program]]. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

[Applies when plan design does not include benefits for new pharmaceutical products.]

[New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product, for the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our Pharmaceutical Product List Management Committee.
- December 31st of the following calendar year.]

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

[Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.]

Orthotic Device - an external device that is, (i) intended to restore physiological function or cosmesis to a Covered Person; and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the Covered Person using the device prior to concurrent with the delivery of the device to the Covered Person.

Orthotic Service - the evaluation and treatment of a condition that requires the use of an Orthotic Device.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.]

[Per Occurrence Deductible - for Benefit plans that have a Per Occurrence Deductible, this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

When a Benefit plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of a Per Occurrence Deductible and for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.]

Pharmaceutical Product(s) - U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Pharmaceutical Product List - a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration (FDA). This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Pharmaceutical Product has been assigned through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Pharmaceutical Product List Management Committee - the committee that we designate for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy*.
- This *Certificate*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Enrolling Group.

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

[Preexisting Condition - an Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the [three] [six] month period ending on the person's

enrollment date. (The enrollment date is the date the person became covered under the Policy or, if earlier, the first day of any waiting period under the Policy.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.]

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

¹Applies when OB/GYN Physicians are considered Primary Physicians.]

²Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services and all clinicians are considered primary physicians.]

³Applies when clinicians providing psychological testing are not considered specialists.]

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, [¹obstetrics/gynecology,] family practice or general medicine. [²For [Mental Health Services] [and] [Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Primary Physician [³for the provision of all services other than psychological testing].]

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Prosthetic Device - an external device that is (i) intended to replace an external body part for the purpose of restoring physiological function or cosmesis to a patient; and (ii) custom designed, fabricated, assembled, fitted, or adjusted for patient using the device prior to or concurrent with being delivered to the Covered Person.

Prosthetic Service - the evaluation and treatment of a condition that requires the use of a Prosthetic Device.

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Residential Treatment Facility - a facility which provides a program of effective [Mental Health Services] [or] [Substance Use Disorder Services] treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.

- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.]

Rider - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

[Applies when the Shared Savings Program is included. "Shared Savings Program" is bracketed to accommodate possible name change. This Shared Savings Program reference will not be included in a Choice COC.]

[[Shared Savings Program] - the [Shared Savings Program] provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the [Shared Savings Program] to pay claims when doing so will lower Eligible Expenses. We do not credential the [Shared Savings Program] providers and the [Shared Savings Program] providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by [Shared Savings Program] providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the [Shared Savings 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 deductible.]

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* does not include [Mental Illness][mental illness] or substance use disorders, regardless of the cause or origin of the [Mental Illness][mental illness] or substance use disorder.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

¹*Applies when OB/GYN Physicians are considered Primary Physicians.]*

²*Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services and all clinicians are considered specialists.]*

³*Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services and only clinicians that perform psychological testing are considered specialists.]*

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, [¹obstetrics/gynecology,] family practice or general medicine. [²For [Mental Health Services] [and] [Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Specialist Physician.] [³For [Mental Health Services] [and] [Substance Use Disorder

Services], a licensed clinician who provides psychological testing is considered on the same basis as a Specialist Physician.]

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

[Applies when plan design includes benefits for substance use disorder services.]

[Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.]

[Applies when group purchases extended coverage for total disability.]

[Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.]

[Applies when plan design includes benefits for mental health services, neurobiological disorder/autism spectrum disorder services or substance use disorder services.]

[Transitional Care - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

[Applies when plan design includes benefits for mental health services or neurobiological disorder/autism spectrum disorder services, but not substance use disorder services.]

[Transitional Care - Mental Health Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are supervised living arrangements which are residences that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence

available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.
- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
 - If the service is one that requires review by the *U.S. Food and Drug Administration (FDA)*, it must be *FDA*-approved.
 - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
 - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
 - At least two studies from more than one institution must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
 - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.