Filing at a Glance

Company: Unimerica Insurance Company
Product Name: 2009 MHP Amendment AR
TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other
Filing Type: Form

SERFF Tr Num: UHLC-126866589
SERFF Status: Closed-Approved-Closed
Co Tr Num:

Author: Ebony Terry
Date Submitted: 10/20/2010

State: Arkansas
State Tr Num: 47094

State Status: Approved-Closed
Reviewer(s): Rosalind Minor
Disposition Date: 04/11/2011
Disposition Status: Approved-Closed

Implementation Date Requested:
Implementation Date:
State Filing Description:

General Information

Project Name:
Project Number:
Requested Filing Mode:
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type:
Filing Status Changed: 04/11/2011
State Status Changed: 04/11/2011
Created By: Ebony Terry
Corresponding Filing Tracking Number:
PPACA: Not PPACA-Related
PPACA Notes: null
Filing Description:
2009 MHP Amendment

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

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Filing Company Information

Unimerica Insurance Company	CoCode: 91529	State of Domicile: Wisconsin
PO Box 150450	Group Code: 707	Company Type: Life and Health
Hartford, CT 0606115-0450	Group Name:	State ID Number:
(860) 702-6017 ext. [Phone]	FEIN Number: 52-1996029	

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Unimerica Insurance Company	$50.00	10/20/2010	40954246

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/11/2011	04/11/2011
Approved-Closed	Rosalind Minor	11/09/2010	11/09/2010

Disposition

Disposition Date: 04/11/2011
Implementation Date:
Status: Approved-Closed
Comment:

This submission is being closed and will retain the original approved date of 11/9/10.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126866589*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*47094*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2009 MHP Amendment AR*		
Project Name/Number:	*/*		

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

Disposition

Disposition Date: 11/09/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126866589*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*47094*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2009 MHP Amendment AR*		
Project Name/Number:	*/*		

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

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/09/2010	MHPAMD.I.09.AR	Certificate Amendment, Insert Page, Endorsement or Rider	Mental Health Parity Amendment	Initial			Mental Health Parity Amendment 2009 INS.pdf

Hearing Aid, Mental Health Parity and Special Enrollment Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified as stated below.

Contract Issuance: *Include only if the Amendment is to be mailed separate from the COC and if the 2007 series is modified by other amendments. Do not include when amendment is issued as part of the COC.*

[Because this Amendment reflects changes in requirements of Federal law, to the extent it may conflict with any Amendment issued to you previously, the provisions of this Amendment will govern.]

Because this Amendment is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and in this Amendment below.

For Choice, do not include any of the pre-service benefit confirmation provisions below other than the first sentence.

Prior authorization requirements listed under *[Mental Health and Substance Abuse Services]* in the *Schedule of Benefits* are deleted. [The following [services are] [service is] added to the list of services requiring pre-service notification under *Pre-service Benefit Confirmation* in the *Schedule of Benefits:*

[Pre-service Benefit Confirmation]

[1]Include for Choice Plus.

[2]Include for Options PPO and Non-Differential PPO.

[[1]When you choose to receive certain Covered Health Services from non-Network providers, you] [[2]You] are responsible for notifying us before you receive these services.

To notify us, call the telephone number for *Customer Care* on your ID card.

Covered Health Services which require pre-service notification:

- [Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.]
- [Neurobiological Disorders - Autism Spectrum Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), intensive outpatient program treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home; [Applied Behavioral Analysis (ABA).]]
- [Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; psychological testing; outpatient treatment of opioid dependence; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.]]

Include when COC was issued to a group including a hearing aid benefit or when the COC was approved with non-variable language supporting a hearing aid mandate. Include as standard for groups of 2 to 15 and 15+.

[Hearing Aids in the *Certificate*, *Section 1: Covered Health Services* is deleted and replaced with the following Covered Health Service description:]

[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 the *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.

Include when COC was issued to a group including a hearing aid benefit or when the COC was filed with language supporting a hearing aid mandate.

[*Hearing Aids* in the *Schedule of Benefits* is deleted and replaced with the following Covered Health Service description:]

[1]Include for Choice Plus and Options PPO. [2]Include for Choice. Delete both for Non-Differential PPO.

[[1]When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.]

[[2]When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

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 Network and Non-Network references for Choice Plus and Options PPO; delete references and the Non-Network row for Choice and Non-Differential PPO. Include as standard for groups of 2 to 15 and 15+. **[9.] Hearing Aids**			
Include the limit selected by the group. *Limit must be the same as annual limits selected for Durable Medical Equipment and Prosthetics, or $5,000 per year if DME and Prosthetic limits*	***[[1]Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

[1]*Include for Choice Plus and Options PPO.* [2]*Include for Choice. Delete both for Non-Differential PPO.* ***[[1]When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.]*** ***[[2]When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]***			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
exceed $5,000 per year. [Limited to $[2,800 - 5,000] in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every [year] [[three-five] years].] *To be removed for HSA plans.* [No Copayment, Coinsurance or Deductible will be applicable to Network or non-Network Hearing Aid Coverage.]	***[[1]Non-Network]*** [[50 - 100]%]	[Yes] [No]	[Yes] [No]

[Mental Health and Substance Abuse Services - Inpatient and Intermediate]* [and] *[Mental Health and Substance Abuse Services - Outpatient]* in the Certificate, Section 1: Covered Health Services are deleted and replaced with the following Covered Health Service descriptions for *[Mental Health Services,] [Neurobiological Disorders - Autism Spectrum Disorder Services]* and *[Substance Use Disorder Services]:

Note: The bracketed covered health service numbers here and in the schedule will not be included when the document is issued in amendment format only; including it will be used only to support accurately embedding amendment provisions into the COC or Schedule where permitted.

Include when group purchases plan with MH benefits. [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 outpatient or inpatient 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.]

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

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

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

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

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories in this *Certificate*.

Benefits include the following services provided on either an outpatient or inpatient 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 sold.

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

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.]

Include when group purchases plan with SUD benefits. [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 outpatient or inpatient 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.]

***[Mental Health and Substance Abuse Services - Inpatient and Intermediate]* [and] *[Mental Health and Substance Abuse Services - Outpatient]* in the *Schedule of Benefits* are deleted and replaced with the following:**

[1]Include for Choice Plus and Options PPO. [2]Include for Choice. Delete both for Non-Differential PPO.

[[1]When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.]

[[2]When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Include for groups that purchase mental health benefits. [Include as standard for groups of 2 to 15] **[16.] [Mental Health Services]**			
Do not include Pre-Service Notification Requirement for Choice. **[Pre-Service Notification Requirement]** *[1]Include for Choice Plus.* [For [1]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 notify us 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 notify us before the following services are received: intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home. If you fail to notify us as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[1]Include Network and Non-Network references for Choice Plus and Options PPO; delete references and the Non-Network row for Choice and Non-Differential PPO. *Limits will not apply to groups of 51+.* [Inpatient *Mental Health Services* are limited to [10 - 100] days per year.] [Outpatient *Mental Health Services* are limited to [10 - 100] visits per year.] [Non-Network Benefits for inpatient *Mental Health Services* are limited to	***[[1]Network]*** *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 -	[Yes] [No]	[Yes] [No]

[1]Include for Choice Plus and Options PPO. [2]Include for Choice. Delete both for Non-Differential PPO.

[[1]When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.]

[[2]When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
[10 - 100] days per year.]	1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]		
[Non-Network Benefits for outpatient *Mental Health Services* are limited to [10 - 100] visits per year.] [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: • [10 - 100] days per year for inpatient *Mental Health Services* and *Neurobiological Disorders - Autism Spectrum Disorder Services*. • [10 - 100] visits per year for outpatient *Mental Health Services* and *Neurobiological Disorders - Autism Spectrum Disorder Services*.]]	*[Outpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.] [100% for visits for medication management]	[Yes] [No]	[Yes] [No]
[Benefits for any combination of *Mental Health Services* described in this section and *Substance Use Disorder Services* described below are limited as follows: • [10 - 100] days per year for Inpatient *Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Mental Health Services* and *Substance Use Disorder Services*.]]	***[[1]Non-Network]*** *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per	[Yes] [No]	[Yes] [No]

[1]Include for Choice Plus and Options PPO. [2]Include for Choice. Delete both for Non-Differential PPO.

[[1]When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.]

[[2]When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Inpatient Stay]		
[Benefits for any combination of *Mental Health Services* described in this section and *Neurobiological Disorders - Autism Spectrum Disorder Services* and *Substance Use Disorder Services* described below are limited as follows: • [10 - 100] days per year for inpatient *Neurobiological Disorders - Autism Spectrum Disorder Services, Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Neurobiological Disorders - Autism Spectrum Disorder Services, Mental Health Services* and *Substance Use Disorder Services*.]]	*[Outpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.] [100% for visits for medication management]	[Yes] [No]	[Yes] [No]
Include for groups that purchase mental health benefits. **[17.] [Neurobiological Disorders - Autism Spectrum Disorder Services]**			

Do not include Pre-Service Notification Requirement for Choice.

[Pre-Service Notification Requirement]

[1]Include for Choice Plus.

[For [[1]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 notify us prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, [[1]for Non-Network Benefits] you must notify us before the following services are received: intensive outpatient program treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home[; Applied Behavioral Analysis].

If you fail to notify us as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]

[1]Include for Choice Plus and Options PPO. [2]Include for Choice. Delete both for Non-Differential PPO. ***[[1]When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.]*** ***[[2]When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]***			
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 Network and Non-Network references for Choice Plus and Options PPO; delete references and the Non-Network row for Choice and Non-Differential PPO. *Limits will not apply to groups of 51+.* [Inpatient *Neurobiological Disorders - Autism Spectrum Disorder Services* are limited to [10 - 100] days per year.] [Outpatient *Neurobiological Disorders - Autism Spectrum Disorder Services* are limited to [10 - 100] visits per year.] [Non-Network Benefits for inpatient *Neurobiological Disorders - Autism Spectrum Disorder Services* are limited to [10 - 100] days per year.]	***[[1]Network]*** *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No]
[Non-Network Benefits for outpatient *Neurobiological Disorders - Autism Spectrum Disorder Services* are limited to [10 - 100] visits per year.] [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: • [10 - 100] days per year for inpatient *Neurobiological Disorders - Autism Spectrum Disorder Services* and *Mental Health Services*. • [10 - 100] visits per year for outpatient *Neurobiological Disorders - Autism Spectrum Disorder Services* and *Mental Health Services*.]]	*[Outpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.] [100% for visits for medication management]	[Yes] [No]	[Yes] [No]
[Benefits for any combination of *Neurobiological Disorders - Autism Spectrum Disorder Services* described	***[[1]Non-Network]*** *[Inpatient]*	[Yes] [No]	[Yes] [No]

[1]Include for Choice Plus and Options PPO. [2]Include for Choice. Delete both for Non-Differential PPO.

[[1]When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.]

[[2]When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]

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 this section, *Mental Health Services* described above and *Substance Use Disorder Services* described further below are limited as follows: • [10 - 100] days per year for inpatient *Neurobiological Disorders - Autism Spectrum Disorder Services, Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Neurobiological Disorders - Autism Spectrum Disorder Services, Mental Health Services* and *Substance Use Disorder Services*.]]	[[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]		
	[Outpatient] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.] [100% for visits for medication management]	[Yes] [No]	[Yes] [No]
Include for groups that purchase substance use disorder benefits. *[Include as standard for groups of 2 to 15]* **[30.] [Substance Use Disorder Services]**			

Do not include Pre-Service Notification Requirement for Choice.

[Pre-Service Notification Requirement]

[1]*Include for Choice Plus and Options PPO.* [2]*Include for Choice. Delete both for Non-Differential PPO.* ***[[1]When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.]*** ***[[2]When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]***			
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 for Choice Plus.* [For [1]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 notify us prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, [[1]for Non-Network Benefits] you must notify us before the following services are received: Services requiring pre-service notification: intensive outpatient program treatment; psychological testing; outpatient treatment of opioid dependence; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home. If you fail to notify us as required, Benefits will be reduced to [50 - 95]% of Eligible Expenses.]			
[1]*Include Network and Non-Network references for Choice Plus and Options PPO; delete references and the Non-Network row for Choice and Non-Differential PPO.* *Limits will not apply to groups of 51+.* [Inpatient *Substance Use Disorder Services* are limited to [10 - 100] days per year.] [Outpatient *Substance Use Disorder Services* are limited to [10 - 100] visits per year.] [Non-Network Benefits for inpatient *Substance Use Disorder Services* are limited to [10 - 100] days per year.] [Non-Network Benefits for outpatient *Substance Use Disorder Services* are limited to [10 - 100] visits per year.] [Benefits for any combination of *Substance Use Disorder Services* described in this section and *Mental Health Services* described above are limited as follows: • [10 - 100] days per year for inpatient *Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for	***[[1]Network]*** *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No]	[Yes] [No]

[1]*Include for Choice Plus and Options PPO.* [2]*Include for Choice. Delete both for Non-Differential PPO.* ***[[1]When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.]*** ***[[2]When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]***			
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 *Mental Health Services* and *Substance Use Disorder Services*.]]			
[Benefits for any combination of *Substance Use Disorder Services* described in this section and *Mental Health Services* and *Neurobiological Disorders - Autism Spectrum Disorder Services* described above are limited as follows: • [10 - 100] days per year for inpatient *Neurobiological Disorders - Autism Spectrum Disorder Services, Mental Health Services* and *Substance Use Disorder Services*. • [10 - 100] visits per year for outpatient *Neurobiological Disorders - Autism Spectrum Disorder Services, Mental Health Services* and *Substance Use Disorder Services*.]]	*[Outpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.] [100% for visits for medication management] ***[[1]Non-Network]*** *[Inpatient]* [[50 - 100]%] [100% after you pay a Copayment of $[100 - 1,000] per day] [100% after you pay a Copayment of $[100 - 2,000] per Inpatient Stay] [100% after you pay a Copayment of $[100 - 1,000] per day to a maximum Copayment of $[100 - 5,000] per Inpatient Stay]	[Yes] [No] [Yes] [No]	[Yes] [No] [Yes] [No]

[1]Include for Choice Plus and Options PPO. [2]Include for Choice. Delete both for Non-Differential PPO. ***[[1]When Benefit limits apply, the limit refers to any combination of [Designated Network Benefits,] Network Benefits and Non-Network Benefits unless otherwise specifically stated.]*** ***[[2]When Benefit limits apply, the limit stated includes Covered Health Services provided at a Designated Network level of Benefits unless otherwise specifically stated.]***			
Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	[Outpatient] [[50 - 100]%] [100% after you pay a Copayment of $[5 - 100] per visit] [100% after you pay a Copayment of $[5 - 75] per individual visit; $[5 - 75] per group visit.] [100% for visits for medication management]	[Yes] [No]	[Yes] [No]

Exclusions for *Mental Health/Substance Abuse* in the *Certificate* under *Section 2: Exclusions and Limitations* are deleted and replaced with the following:

[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.]

[1]Applies 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 [[1]that 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.

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

[R] Substance Use Disorders

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

Exclusion 5 applies when plan design does not include benefits for substance use disorders 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.

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

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

Exclusions for *Vision and Hearing* in the *Certificate* under *Section 2: Exclusions and Limitations,* are replaced with the following:

[V.] Vision and Hearing

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

Include when group does not purchase benefits for vision exams.

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

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

Delete exclusion when benefits for vision therapy are provided.

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

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

[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.

The provision in the *Certificate* under *Section 3: When Coverage Begins, Special Enrollment Period* is replaced with the following:

Special Enrollment Period

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

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

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

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

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

- Birth.
- Legal adoption.
- Placement for adoption.

- Marriage.
- [[1]Registering a Domestic Partner.]

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

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

When an event takes place (for example, a birth, marriage, 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 within 31 days of the event unless otherwise noted above.

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

[1]Include when Benefits are provided for either MH or SUD Services. Include when Benefits are provided for MH Services. [2]Include when Benefits are provided for SUD Services. [3]Include when Benefits are provided for both MH and SUD Services. [4]Include when Benefits are not provided for either MH or SUD Services.

The definition of Intermediate Care is deleted. The definitions of [[1]Alternate Facility,] Covered Health Services, Experimental or Investigational Service(s), [[2]Mental Health Services,] [[1]Mental Health/Substance Abuse Designee,] [[2]Mental Illness,] [[1]Primary Physician,] [[4]and] Sickness[[1],] [[1]Specialist Physician,] [[3]Substance Abuse Services] [[1]and] [[1]Transitional Care] in the *Certificate* under *Section 9: Defined Terms* are deleted and replaced with the following:

Include when Benefits are provided for either MH or SUD Services.

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

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

[1]Include when group purchases MH (including Neurobiological Disorders) or SUD coverage. [2]Include when Benefits are provided only for MH Services. [3]Include when Benefits are provided only for SUD Services. [4]Include when Benefits are provided for both MH and SUD Services.

[[1]An Alternate Facility may also provide [[2]Mental Health Services] [[4]or] [[3]Substance Use Disorder Services] on an outpatient or inpatient basis.]]

[1]Include when group purchases MH (including Neurobiological Disorders). [2]Include when group does not purchase MH benefits.

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

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, [[1]Mental Illness,][[2]mental illness,] substance use disorders, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in the *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in the *Certificate* under *Section 2: Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines and national specialty society guidelines.

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

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

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)

- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

Include when the group purchases benefits for clinical trials.

- [Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.]
- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

Include when group purchases MH (including Neurobiological Disorders) coverage.

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

Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

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

Include when group purchases MH (including Neurobiological Disorders) coverage.

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

Include definition when Benefits are provided for either MH or SUD Services.

[1]Include when group purchases MH (including Neurobiological Disorders) or SUD coverage and all clinicians are considered primary physicians. [5]Include when clinicians providing psychological testing are not considered specialists. Delete #1 entirely when all clinicians are considered specialists.

[2]Include when group purchases MH benefits. [3]Include when group purchases SUD benefits. [4]Include when group purchases both MH and SUD benefits.

[**Primary Physician** - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. [[1]For [[2]Mental Health Services] [[4]and] [[3]Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Primary Physician [[5]for the provision of all services other than psychological testing].]]

[1]Include when group purchases MH benefits (including Neurobiological Disorders). [2]Include when group does not purchase MH benefits.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in the *Certificate* does not include [[1]Mental Illness][[2]mental illness] or substance use disorders, regardless of the cause or origin of the [[1]Mental Illness][[2]mental illness] or substance use disorder.

Include definition when Benefits are provided for either MH or SUD Services.

[1]Include when group purchases MH (including Neurobiological Disorders) or SUD coverage and all clinicians are considered specialists.

[2]Include when group purchases MH (including Neurobiological Disorders) or SUD coverage and only clinicians that perform psychological testing are considered specialists.

[3]Include when group purchases MH benefits. [4]Include when group purchases SUD benefits. [5]Include when group purchases both MH and SUD benefits.

[Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. [[1]For [[3]Mental Health Services] [[5]and] [[4]Substance Use Disorder Services], any licensed clinician is considered on the same basis as a Specialist Physician.] [[2]For [[3]Mental Health Services] [[5]and] [[4]Substance Use Disorder Services], a licensed clinician who provides psychological testing is considered on the same basis as a Specialist Physician.]]

Include when group purchases SUD benefits.

[Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.]

Include when group purchases MH (including Neurobiological Disorders) and SUD coverage.

[Transitional Care - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

Include when group purchases MH (including Neurobiological Disorders) but not SUD coverage.

[Transitional Care - Mental Health Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are supervised living arrangements which are residences that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.]

Include statement when benefits for MH, Autism or SUD benefits are sold. [1]Include only when benefits for Mental Health Services for Autism Spectrum Disorders are purchased.

[The following definitions of [[1]Autism Spectrum Disorders,] Intensive Outpatient Treatment, Partial Hospitalization/Day Treatment and Residential Treatment Facility are added to the *Certificate* under *Section 9: Defined Terms*:]

Include when benefits for Mental Health Services for Autism Spectrum Disorders are purchased.

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

Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

[1]Include when Benefits are provided only for MH Services. [2]Include when Benefits are provided only for SUD Services. [3]Include when Benefits are provided for both MH and SUD Services.

[Intensive Outpatient Treatment - a structured outpatient [[1]Mental Health][[3]or][[2]Substance Use Disorder] treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.]

Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

[Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.]

Include when group purchases MH (including Neurobiological Disorders) or SUD coverage.

[1]Include when Benefits are provided only for MH Services. [2]Include when Benefits are provided only for SUD Services. [3]Include when Benefits are provided for both MH and SUD Services.

[Residential Treatment Facility - a facility which provides a program of effective [[1]Mental Health Services] [[3]or] [[2]Substance Use Disorder Services] treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.]

Contract Issuance: *Include Effective Date only if Amendment is to be mailed separate from the COC. Do not include effective date when amendment is issued as part of the COC.*

[Effective Date of this Amendment: _____]

_____

(Name and Title)

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	11/09/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	11/09/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	11/09/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	11/09/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved-Closed	11/09/2010
Comments:			
Attachment:			
MHP Cover.pdf			

UnitedHealthcare®
A UnitedHealth Group Company

October 14, 2010

Rosalind Minor

Arkansas Insurance Department

Little Rock, Arkansas 72201

Re: UnitedHealthcare Insurance Company

NAIC No. 79413

Mental Health Parity and Addiction Equity Act of 2008 Amendment MHPAMD.I.09.AR

Dear Ms. Minor:

On behalf of UnitedHealthcare Insurance Company, I am submitting the enclosed group health amendment for your Department's review and approval. We are requesting to use this amendment in conjunction with our approved 2009 product series, form filing Policy.I.09.AR et all, approved on August 14, 2009. This amendment is being filed to incorporate mental health parity requirements as required under The Mental Health Parity and Addiction Equity Act of 2008.

Revisions made to comply with the Federal Mental Health Parity Interim Rules are described below:

- Previous prior authorization requirement language changed to achieve parity in notification requirements with medical benefits. For example: 1) " Authorization requirement" language changed to "pre-service notification" language and 2) the list of non-network services that require notification is now revised to include specific outpatient services under the mental health, substance use disorder and neurobiological disorder benefit categories.
- Cost sharing language that referenced that cost sharing is dependent upon where the covered service is provided has been removed under the mental health, substance use disorders and the neurobiological disorders benefit categories. Parity requirements for cost sharing will be accommodated via the filed variable costing sharing provisions.
- Exclusions for mental health, neurobiological disorders and substance use disorders revised.

Our intent is to use this amendment for large and small employer groups.

Because the enclosed form has been modified to reflect the laws and regulations of Arkansas, it will not be filed with Connecticut, our State of Domicile.

Our intent is to use this form to convey deletion of, addition of, or change in the specifics of a provision previously filed with your Department.

Explanation Variable Text

Included in this amendment are the following features:

- **Non-variable Text** that always appears in an issued document.
- **Variable Text** that may or may not appear in an issued document depending on the specific product and plan design selected by the Enrolling Group. Variable text is enclosed in [brackets]. Whenever text is bracketed, we have included text that explains the logic of the variable; brackets do not appear in the document issued to a member.
- **Instruction text** provides the logic for when text is included or removed. Please note that instruction text appears only in the filing copy and will not appear in the document issued to a member. Following are two examples of instruction text:

Include when group purchases plan with MH benefits.

Limits will not apply to groups of 51+.

Information contained within this form 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.

We would also like to reserve the right to build the amendatory language into the [Certificate] [Schedule] or leave it in the amendment format, whichever we deem most appropriate.

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

Sincerely,

Ebony Terry

Compliance Analyst

Enclosures