

State: Arkansas Filing Company: UnitedHealthcare Insurance Company of the River Valley

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO

Product Name: UHIC RV AR Heritage Plus Rev 8.12

Project Name/Number: UHIC RV AR Heritage Plus Rev 8.12/UHIC RV AR Heritage Plus Rev 8.12

Filing at a Glance

Company: UnitedHealthcare Insurance Company of the River Valley

Product Name: UHIC RV AR Heritage Plus Rev 8.12

State: Arkansas

TOI: H16G Group Health - Major Medical

Sub-TOI: H16G.001A Any Size Group - PPO

Filing Type: Form

Date Submitted: 10/02/2012

SERFF Tr Num: UHLC-128710778

SERFF Status: Closed-Approved-Closed

State Tr Num:

State Status: Approved-Closed

Co Tr Num: UHIC RV AR HERITAGE PLUS REV 8.12

Implementation: On Approval

Date Requested:

Author(s): Kelly Smith

Reviewer(s): Rosalind Minor (primary)

Disposition Date: 10/02/2012

Disposition Status: Approved-Closed

Implementation Date:

State Filing Description:

State: Arkansas Filing Company: UnitedHealthcare Insurance Company of the River Valley
 TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
 Product Name: UHIC RV AR Heritage Plus Rev 8.12
 Project Name/Number: UHIC RV AR Heritage Plus Rev 8.12/UHIC RV AR Heritage Plus Rev 8.12

General Information

Project Name: UHIC RV AR Heritage Plus Rev 8.12 Status of Filing in Domicile: Pending
 Project Number: UHIC RV AR Heritage Plus Rev 8.12 Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Group
 Submission Type: New Submission Group Market Size: Small and Large
 Group Market Type: Employer Overall Rate Impact:
 Filing Status Changed: 10/02/2012 Deemer Date:
 State Status Changed: 10/02/2012 Submitted By: Kelly Smith
 Created By: Kelly Smith
 Corresponding Filing Tracking Number: UHIC RV AR Heritage Plus Rev 8.12

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Primary Advantage Plans for AR River Valley, chedule of Benefits and Amendment to COC

Company and Contact

Filing Contact Information

Kelly Smith, Manager RGA Kelly_Smith@uhc.com
 800 King Farm Blvd. 240-632-8061 [Phone]
 Suite 500
 Rockville, MD 20850

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: 50x2
 Per Company: No

Company	Amount	Date Processed	Transaction #
UnitedHealthcare Insurance Company of the River Valley	\$100.00	10/02/2012	63325025

State: Arkansas Filing Company: UnitedHealthcare Insurance Company of the River Valley
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: UHIC RV AR Heritage Plus Rev 8.12
Project Name/Number: UHIC RV AR Heritage Plus Rev 8.12/UHIC RV AR Heritage Plus Rev 8.12

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/02/2012	10/02/2012

State: Arkansas **Filing Company:** UnitedHealthcare Insurance Company of the River Valley
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: UHIC RV AR Heritage Plus Rev 8.12
Project Name/Number: UHIC RV AR Heritage Plus Rev 8.12/UHIC RV AR Heritage Plus Rev 8.12

Disposition

Disposition Date: 10/02/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter UHIC RV AR Heritage Plus Rev 8.12	Approved-Closed	Yes
Supporting Document	Redline Comparison	Approved-Closed	Yes
Form	UHIC RV AR Heritage Plus Rev 8.12	Approved-Closed	Yes
Form	UHIC.HDHP.I.AR	Approved-Closed	Yes

State: Arkansas **Filing Company:** UnitedHealthcare Insurance Company of the River Valley
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: UHIC RV AR Heritage Plus Rev 8.12
Project Name/Number: UHIC RV AR Heritage Plus Rev 8.12/UHIC RV AR Heritage Plus Rev 8.12

Form Schedule

Lead Form Number: UHIC RV AR Heritage Plus Rev 8.12

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 10/02/2012	AMD.HRSA.1.0 1.AR, etalUHIC RV AR Heritage Plus Rev 8.12	SCH	UHIC RV AR Heritage Plus Rev 8.12	Initial:	51.400	UHIC RV AR Heritage Plus Rev 8-12.pdf
2	Approved-Closed 10/02/2012	UHIC.RV.HDH P.I.AR	POLA	UHIC.HDHP.I.AR	Initial:	59.600	UHIC.RV.HDHP.I.AR.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

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

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

Deductibles and Maximums	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
--------------------------	--------------------------------------	--

Deductible [(calendar year)] [(Contract Period)]

[[Individual] [Self Only]	[\$100-\$10,000] [Not applicable] [for self only coverage]	[\$200-\$20,000] [for self only coverage]
[Family] [Self and Family]	[\$100-\$30,000] [for family coverage] [Not applicable]	[\$200-\$60,000] [for family coverage]

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

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

{OR}

[[Individual] [Self Only]	[\$100-\$20,000] [Not applicable] [for self only coverage]
[Family] [Self and Family]	[\$100-\$60,000] [for family coverage] [Not applicable]

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

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

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

[Individual] [Self Only]	[\$100-\$20,000] [for self only coverage] [Not applicable]	[\$200-\$40,000] [for self only coverage] [Not applicable]
[Family] [Self and Family]	[\$100-\$60,000] [for family coverage] [Not applicable]	[\$200-\$120,000] [for family coverage] [Not applicable]

(The In-Network Maximum Out-of-Pocket Expense and Out-of-Network Maximum Out-of-Pocket Expense are separate.) [All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.] [Once the family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the [calendar year] [Contract Period].] [Member Copayments do not accumulate to the Out-of-Pocket Maximum.]

{OR}

[Individual] [Self Only]	[\$100-\$40,000] [for self only coverage] [Not applicable]
[Family] [Self and Family]	[\$200-\$120,000] [for family coverage] [Not applicable]

(The In-Network Maximum Out-of-Pocket Expense and Out-of-Network Maximum Out-of-Pocket Expense are combined.) [All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.] [Once the family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the [calendar year] [Contract Period] [Member Copayments do not accumulate to the Out-of-Pocket Maximum.][Deductible does not apply to the Maximum Out-of-Pocket Expense.]

[Maximum Policy Benefit per Member]	[None] [\$1,000,000-\$10,000,000][Unlimited]	[None] [\$1,000,000-\$10,000,000][Unlimited]
--	--	--

[(Plan pays a maximum benefit which is separate for In-Network and Out-of-Network.)]

{OR}

[Maximum Policy Benefit per Member]	[None] [\$1,000,000-\$10,000,000][Unlimited]
--	--

[(Plan pays a maximum benefit which includes both In-Network and Out-of-Network.)]

[4th Quarter Deductible Carryover]	[Applicable] [Not Applicable]	[Applicable] [Not Applicable]
--	-------------------------------	-------------------------------

{OR}

Benefits for Covered Services	Participating Provider In-Network Member Pays	Non-Participating Provider (1) Out-of-Network Member Pays
Preventive Care Services		
<i>("Preventive Care" refers to examinations and services recommended by the U.S. Preventive Services Task Force or preventive care services mandated by state or federal law or regulation.)</i>		
Physical Exams/Well-Child Care	[[[\$0 Copayment per visit] [Balance of Allowed Charge paid at 100%.] [[0% of Allowed Charge] [Deductible does not apply]]Covered at 100%.]	[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply] [Not Covered]
Immunizations	Charge paid at 100% for children newborn through 18 years of age For members over the age of 18, [[[\$0 Copayment per visit] [Balance of Allowed Charge paid at 100%.] [[0% of Allowed Charge] [Deductible does not apply]].Covered at 100%.]	Charge paid at 100% for children newborn through 18 years of age. . For members over the age of 18, [0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply] [Not Covered].
Laboratory and X-ray	[[[\$0 Copayment per visit] [Balance of Allowed Charge paid at 100%.] [[0% of Allowed Charge] [Deductible does not apply]]Covered at 100%.]	[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply] [Not Covered]
Physician Office Services		
Office Visits.	[[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Deductible does not apply if services received from a Primary Care Physician (PCP).]	[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply.]
Office Surgery	[[[\$0-\$500] Copayment per [visit]surgery] [[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Deductible does not apply if services received from a Primary Care Physician (PCP).]	[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply.]
Allergy Testing	[[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Deductible does not apply if services received from a Primary Care Physician (PCP).]	[[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply.] [Not covered]
Allergy Injections	<i>For PCP/Specialist copay option, validate first with plan build</i> [[[\$0-\$250] Copayment per injection] [[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit]](if no office visit billed; otherwise only Office Visit [copayment] applies))] [Balance of Allowed Charge paid at 100%.][then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Deductible does not apply if services received from a Primary Care Physician (PCP).]	[[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply.] [Not covered]

Benefits for Covered Services	Participating Provider In-Network Member Pays	Non-Participating Provider (1) Out-of-Network Member Pays
Other Injections	<i>For PCP/Specialist copay option, validate first with plan build</i> [[\$0-\$250] Copayment per injection] [[\$0-\$75] [PCP]/] [\$5-\$100] [Specialist] Copayment per visit[(if no office visit billed; otherwise only Office Visit [copayment]applies))] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Deductible does not apply if services received from a Primary Care Physician (PCP).]	[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply.]
Maternity Physician Services	[[\$0-\$750] Copayment per pregnancy] [[\$0-\$75] [PCP]/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%][then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply.]
Newborn Physician Services Inpatient Outpatient	<i>See “Physician Services at a Facility other than the Office” and “Facility Services.”</i> <i>See “Physician Office Services.”</i>	
Physician Services at a Facility other than the Office		
Home Visits	[[\$0-\$75] [PCP]/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%][then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Deductible does not apply if services received from a Primary Care Physician (PCP).]	[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply]
Inpatient Facility Visits	[[\$0-\$75] [PCP]/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%][then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply]
Outpatient Facility Visits	[[\$0-\$75] [PCP]/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply]
Inpatient Surgery	[[\$0-\$1,000] Copayment per surgery] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply]
Outpatient Surgery	[[\$0-\$1,000] Copayment per surgery] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply]
[Morbid Obesity Surgery (2)]	<i>[See “Physician Office Services,” “Physician Services at a Facility other than the Office,” and “Facility Services.”]</i>	
[Any combination of In-Network and Out-of-Network Benefits are limited to a \$[50,000 – 250,000] maximum policy benefit per member.]		

Benefits for Covered Services	Participating Provider In-Network Member Pays	Non-Participating Provider (1) Out-of-Network Member Pays
Emergency Services		
<i>[(Follow-up care obtained in the emergency room is not covered.)]</i>		
Emergency Room Physician	[[[\$0-\$1000] Copayment per visit] [Balance of Allowed Charge paid at 100%.][then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	Covered the same as In-Network Services[[[\$0-\$1000] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
Emergency Room	[[[\$0-\$1000] Copayment per visit for a Medical Emergency.] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge for a Medical Emergency] [after Deductible] [Deductible does not apply] [Emergency Room Copayment waived if admitted.] [Physician's services or other services separately charged may require a separate Copayment and/or Coinsurance in addition to any applicable Deductible, beyond the emergency room facility charge.] [Services must be obtained from a Participating Provider.]	Covered the same as In-Network Services[[[\$0-\$1000] Copayment per visit for a Medical Emergency.] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge for a Medical Emergency] [after Deductible] [Deductible does not apply] [Emergency Room Copayment waived if admitted.] [Physician's services or other services separately charged may require a separate Copayment and/or Coinsurance in addition to any applicable Deductible, beyond the emergency room facility charge.] [Services must be obtained from a Participating Provider.]
Urgent Care Facility	[[[\$0-\$1000] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply.]
Ambulance Services	[[[\$0-\$1000] Copayment] [Balance of Allowed Charge paid at 100%.][then] [[0%-50%] of Allowed Charge][in a Medical Emergency] [after Deductible] [Deductible does not apply] [Non-emergency transports must be approved in advance by UnitedHealthcare.]	[[[\$0-\$1000] Copayment] [Balance of Allowed Charge paid at 100%.][then] [[0%-50%] of Allowed Charge][in a Medical Emergency] [after Deductible] [Deductible does not apply] [Non-emergency transports must be approved in advance by UnitedHealthcare.]
Laboratory and X-ray Services Outpatient	[[[\$0-\$750] Copayment] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]
Office	[[[\$0-\$750] Copayment] [[[\$0-\$75] [PCP]]/[[\$5-\$100] [Specialist] Copayment] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Deductible does not apply if services received from a Primary Care Physician (PCP).]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]
<i>[Use for standard plans or standard contract variations only]</i> [Major Diagnostics (MRI, MRA, CAT and PET Scans)]	[[[\$0-\$1000] Copayment]] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply.]	[0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply.]

[Use for variations only requesting separate locations]

[Major Diagnostics
(MRI, MRA, CAT and PET Scans)]

[Hospital (Outpatient)]

[[$\$0$ - $\$1000$] Copayment] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply.]

[0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply.]

[Office]

[[$\$0$ - $\$75$] [PCP][/] [$\5 - $\$100$] [Specialist] [$\0 - $\$1000$] Copayment][Copayment per visit] [Balance of Allowed Charge paid at 100%] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply.]

[0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply.]

[Note X-ray and laboratory services separately charged by an independent laboratory may require separate Coinsurance and/or Deductible, beyond the physician's office Copayment, Coinsurance and/or Deductible.]

Chemotherapy, Radiation Therapy, Renal Dialysis Services

Hospital (Outpatient)

[[$\$0$ - $\$750$] Copayment] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]

[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]

Office

[[$\$0$ - $\$750$] Copayment] [[$\0 - $\$75$] [PCP][/] [$\5 - $\$100$] [Specialist] Copayment [per visit]] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]

[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]

Facility Services

Inpatient Facility [(2)]

[[$\$0$ - $\$1,500$] Copayment per [surgery][admission] [day] [up to a maximum of [2-5] continuous days] [Balance of Allowed Charge paid at 100%.][then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]

[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]

Outpatient Facility

[[$\$0$ - $\$1,000$] Copayment per[admission] day] [Balance of Allowed Charge paid at 100%.][then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]

[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]

Skilled Nursing Facility [(2)] - *[(Limited to [40-180] Skilled Nursing Facility days per [calendar year] [Contract Period])]* *[(The In-Network and Out-of-Network days are combined.)]* *[Must be approved in advance by UnitedHealthcare]*

[[$\$0$ - $\$1,000$] Copayment per [admission] [day] [up to a maximum of [2-5] continuous days] [Balance of Allowed Charge paid at [50-100]%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]

[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]

Medical Equipment

[(Diabetic supplies do not count toward the [Durable Medical Equipment] [and] [Prosthetic Device] benefit maximum.)]

Durable Medical Equipment [(2)]
[(Plan pays a maximum benefit of [$\$2,500$ - $\$40,000$] per [calendar year] [Contract Period] for Durable Medical Equipment which includes both In-Network and Out-of-Network.)]

[[$\$0$ - $\$500$] Copayment] [Balance of Allowed Charge paid at 100%] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]

[[$\$0$ - $\$500$] Copayment] [then] [[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply] **[Not covered]**

Prosthetic Devices [(2)] [(Plan pays a maximum benefit of [\$2,500-\$40,000] per [calendar year] [Contract Period] for Prosthetic Devices which includes both In-Network and Out-of-Network.)]	[\$0-\$500] Copayment [Balance of Allowed Charge paid at 100%] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[\$0-\$500] Copayment [then] [[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Not covered]
Hearing Aid Devices [(Plan pays a maximum benefit of [\$2,500-\$5,000] per [calendar year] [Contract Period], but shall at least be \$1,400 per ear. [Benefits are limited to a single purchase (including repair/replacement) every [year] [[two-three] years].] [No Copayment, [Coinsurance], or [Deductible] will be applicable to Hearing Aid Coverage]	[\$0-\$500] Copayment [Balance of Allowed Charge paid at 100%] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply.]	[\$0-\$500] Copayment [then] [[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Not covered]
Foot Orthotics (2) [(Limited to one pair custom molded shoe inserts once every [12] [24] months.)]	[\$0-\$500] Copayment [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[\$0-\$500] Copayment [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
Outpatient Rehabilitative Therapy [(Limited to [60-120] visits per [calendar year] [Contract Period])] [(The In-Network and Out-of-Network visits are combined.)]	<i>Use split copay for variations only, validate with plan build</i> [\$0-\$75][PCP][/] [\$5-\$100][Specialist] [[0-\$100] Copayment[per visit]] [Balance of Allowed Charge paid at 100%.] then I [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[\$0-\$100] Copayment [then] [[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]
Outpatient Rehabilitative Therapy includes physical, speech, and occupational therapy and cardiac (Phase I and II) and pulmonary rehabilitation.		
<i>Bracketed language will be used for non-HDHP plans</i> [Spinal Manipulative Services	[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit [Balance of Allowed Charge paid at 100%.][then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply.]
<i>Bracketed language will be used for HDHP plans</i> [Spinal Manipulative Services	[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit [Balance of Allowed Charge paid at 100%.][then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]]	
Home Health Services (2) [(Limited to [60-120] visits per [calendar year] [Contract Period])] [(The In-Network and Out-of-Network visits are combined.)][Must be approved in advance by UnitedHealthcare]	[\$0-\$500] Copayment [Balance of Allowed Charge paid at 100%.][then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[\$0-\$500] Copayment [then] [[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Not covered]
Hospice Services (2)	[\$5-\$500] Copayment per day [Balance of Allowed Charge paid at 100%.][then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]
Respite Care [(2)] [(Limited to [5-10] Respite Care days per [calendar year] [Contract Period])] [(The In-Network and Out-of-Network days are combined.)]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]

Organ and Tissue Transplants [(2)]	<i>[Covered as any other medical condition. See “Physician Office Services,” “Physician Services at a Facility other than the Office,” and “Facility Services.”]</i>	[Not covered] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
[Cornea Transplants]	<i>[Covered as any other medical condition. See “Physician Office Services,” “Physician Services at a Facility other than the Office,” and “Facility Services.”]</i>	
[Mental Health Services]		
[Inpatient Facility] [(2)] [[Limited to [10-100] days per [calendar year] [Contract Period]] [Benefits for any combination of Mental Health and Substance Abuse are limited as follows: Limited to [30-100] days per [calendar year] [Contract Period] for Inpatient Facility services.]]	[[\$0-\$1,500] Copayment per [admission] [day] [up to a maximum of [2-5] continuous days]] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other Inpatient Facility]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other Inpatient Facility]
[Inpatient Physician Visits] [(2)] [[Limited to [10-100] days per [calendar year] [Contract Period]]]	[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Deductible does not apply if services received from a Primary Care Physician (PCP).] [Covered the same as any other Inpatient Physician Visit]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other Inpatient Physician Visit]
[Outpatient Facility] [(2)] [[Limited to [10-100] visits per [calendar year] [Contract Period]] [Benefits for any combination of Mental Health and Substance Abuse are limited as follows: Limited to [10-100] visits per [calendar year] [Contract Period] for Outpatient Facility services.]]	[[\$0-\$1,000] Copayment per [admission][day]] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other Outpatient Facility]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other Outpatient Facility]
[Outpatient Physician Services] [(2)] [[Limited to [10-100] visits per [calendar year] [Contract Period]]]	[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.][then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Deductible does not apply if services received from a Primary Care Physician (PCP).] [Covered the same as any other Outpatient Physician Service]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other Outpatient Physician Service]
[Office Visits] [(2)] [[Limited to [10-100] visits per [calendar year] [Contract Period]]]	[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of allowed charge paid at 100%][then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Deductible does not apply if services received from a Primary Care Physician (PCP).] [Covered the same as any other Office Visit]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other Office Visit]

<p>[Autism Spectrum Disorders]</p> <p>[Benefits for any inpatient and outpatient combination of <i>Autism Spectrum Disorder Services</i>, [for children under (18) years of age.] are limited as follows: [Limited to \$50,000 in Eligible Expenses per year for covered <i>Autism Spectrum Disorder Services</i>]</p>	<p>[\$0-\$1,500] Copayment per [admission] [day] [up to a maximum of [2-5] continuous days]] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]</p> <p>[\$0-\$1,000] Copayment per day] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]</p>	<p>[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]</p>
<p>[Substance Abuse Services]</p> <p>[Inpatient Facility] [(2)] [[Limited to [10-100] days per [calendar year] [Contract Period]] [Benefits for any combination of <i>Mental Health and Substance Abuse</i> are limited as follows: Limited to [30-100] days per [calendar year] [Contract Period] for <i>Inpatient Facility services.</i>]]</p>	<p>[\$0-\$1,500] Copayment per [admission] [day] [up to a maximum of 5 continuous days]] [Balance of Allowed Charge paid at 100%.][then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other Inpatient Facility]</p>	<p>[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other Inpatient Facility]</p>
<p>[Inpatient Physician Visits] [(2)] [[Limited to [10-100] days per [calendar year] [Contract Period]]]</p>	<p>[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of allowed charge paid at 100%][then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Deductible does not apply if services received from a Primary Care Physician (PCP).] [Covered the same as any other Inpatient Physician Visit]</p>	<p>[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other Inpatient Physician Visit]</p>
<p>[Outpatient Facility] [(2)] [[Limited to [10-100] visits per [calendar year] [Contract Period]] [Benefits for any combination of <i>Mental Health and Substance Abuse</i> are limited as follows: Limited to [10-100] visits per [calendar year] [Contract Period] for <i>Outpatient Facility services.</i>]]</p>	<p>[\$0-\$1,000] Copayment per [admission][day] [Balance of allowed charge paid at 100%] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other Outpatient Facility]</p>	<p>[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other Outpatient Facility]</p>
<p>[Outpatient Physician Services] [(2)] [[Limited to [10-100] visits per [calendar year] [Contract Period]]]</p>	<p>[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of allowed charge paid at 100%] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Deductible does not apply if services received from a Primary Care Physician (PCP).] [Covered the same as any other Outpatient Physician service]</p>	<p>[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other Outpatient Physician service]</p>
<p>[Office Visits] [(2)] [[Limited to [10-100] visits per [calendar year] [Contract Period]]]</p>	<p>[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [[0%-50%] of Allowed Charge] [after Deductible] [Balance of allowed charge paid at 100%] [Deductible does not apply] [Deductible does not apply if services received from a Primary Care Physician (PCP).] [Covered the same as any other Office Visit]</p>	<p>[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other Office Visit]</p>

In vitro fertilization [(2)]	[[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit][then][[0%-50%] of Allowed Charge] [after Deductible] [Balance of allowed charge paid at 100%] [Deductible does not apply]][Covered the same as any other Office Visit]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]
[Any combination of In-Network and Out-of-Network Benefits are limited to a \$[15,000 – 50,000] maximum per Member per lifetime.]		
Medical Foods [(2)]	[[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [then][[0%-50%] of Allowed Charge] [after Deductible] [Balance of allowed charge paid at 100%] [Deductible does not apply] [Covered the same as any other Office Visit]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]
[Musculoskeletal Disorders of the Face, Neck or Head [(2)]	[[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [then][[0%-50%] of Allowed Charge] [after Deductible] [Balance of allowed charge paid at 100%] [Deductible does not apply] [Covered the same as any other Office Visit]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]
Orthotic Devices and Services [(2)]	[[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [then][[0%-50%] of Allowed Charge] [after Deductible] [Balance of allowed charge paid at 100%] [Deductible does not apply] [Covered the same as any other Office Visit]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]

Coverage Limitations

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

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

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

[[Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[Exclusions

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

Primary Advantage Plans Amendment

UnitedHealthcare Insurance Company of the River Valley

As described in this Amendment, the Group Health Contract is modified as stated below.

Because this Amendment is part of a legal document (the Group Health Contract), 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 *Article I: Definitions* and in this Amendment below.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company of the River Valley. When we use the words "you" and "your," we are referring to people who are Subscribers, as that term is defined in *Article I: Definitions*.

Section [1.10.1] under [Article 1 - Definitions] in the Certificate is amended by replacing the section with the following:

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

[1.10.1.1 Copayments [(refer to Attachment D for specific benefit detail)].] Remove for use with Embedded HDHP plans

[Remove for use with Embedded HDHP plans](#)

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)

State: Arkansas **Filing Company:** UnitedHealthcare Insurance Company of the River Valley
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: UHIC RV AR Heritage Plus Rev 8.12
Project Name/Number: UHIC RV AR Heritage Plus Rev 8.12/UHIC RV AR Heritage Plus Rev 8.12

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	10/02/2012
Bypass Reason:	Flesch Score - Recorded under Form Schedule tab Application - N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	10/02/2012
Bypass Reason:	Flesch Score -Recorded under Forms tab Application - N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	10/02/2012
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter UHIC RV AR Heritage Plus Rev 8.12	Approved-Closed	10/02/2012
Comments:			
Attachment(s):	UHIC of RV Schedule CVLTR.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Redline Comparison	Approved-Closed	10/02/2012
Comments:			
Attachment(s):	AR Att D Sch of Benefits REDLINE- rev 8 28 12 _2_.pdf		



October 2, 2012

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

Re: UnitedHealthcare Insurance Company of the River Valley
NAIC No. 12231

Forms: Attachment D - Schedule of Benefits Revision and Amendment to COC

Dear Mrs. Minor:

On behalf of UnitedHealthcare Insurance Company of the River Valley, I am submitting the attached revised Schedule of Benefits form for your Department's review and approval. This Schedule of Benefits is intended to replace a previously approved Schedule of Benefits. Once the revised Schedule is approved, this will be the document issued to Members.

A number of changes have been made to the Schedule of Benefits. A Redline Comparison reflecting the changes from the previously approved Schedule is attached to the Supporting Documentation tab.

In addition I am submitting a revised Certificate of Coverage. Only one minor change has been made to section 1.10.1 of the previously approved Certificate.

If you have any questions or concerns regarding this filing, please feel free to contact me.

Sincerely,

Kelly Smith
UnitedHealthcare Insurance Company of the River Valley
800 King Farm Boulevard
Rockville, MD 20850
Ph: 240-632-8061
Email: Kelly_smith@uhc.com

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

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

Deductibles and Maximums	Participating Provider In-Network	Non-Participating Provider (1) Out-of-Network
---------------------------------	--	--

Deductible [(calendar year)] [(Contract Period)]

[[Individual] [Self Only]	[\$100-\$10,000] [Not applicable] [for self only coverage]	[\$200-\$20,000] [for self only coverage]
[Family] [Self and Family]	[\$100-\$ 30,000] [for family coverage] [Not applicable]	[\$200-\$ 60,000] [for family coverage]

Deleted: 20
Deleted: 4

(The In-Network Deductible and Out-of-Network Deductible are separate.)
 [Once the family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the [calendar year] [Contract Period].] [All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.] [Deductible does not apply to the Maximum Out-of-Pocket Expense.]

{OR}

[[Individual] [Self Only]	[\$100-\$20,000] [Not applicable] [for self only coverage]
[Family] [Self and Family]	[\$100-\$ 60,000] [for family coverage] [Not applicable]

Deleted: 4

(The In-Network Deductible and Out-of-Network Deductible are combined.)
 [Once the family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the [calendar year] [Contract Period].] [All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.] [Deductible does not apply to the Maximum Out-of-Pocket Expense.]

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

[Individual] [Self Only]	[\$100-\$20,000] [for self only coverage] [Not applicable]	[\$200-\$40,000] [for self only coverage] [Not applicable]
[Family] [Self and Family]	[\$100-\$ 60,000] [for family coverage] [Not applicable]	[\$200-\$ 120,000] [for family coverage] [Not applicable]

Deleted: 40
Deleted: 8

(The In-Network Maximum Out-of-Pocket Expense and Out-of-Network Maximum Out-of-Pocket Expense are separate.) [All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.] [Once the family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the [calendar year] [Contract Period].] [Member Copayments do not accumulate to the Out-of-Pocket Maximum.]

{OR}

[Individual] [Self Only]	[\$100-\$40,000] [for self only coverage] [Not applicable]
[Family] [Self and Family]	[\$200-\$ 120,000] [for family coverage] [Not applicable]

Deleted: 8

(The In-Network Maximum Out-of-Pocket Expense and Out-of-Network Maximum Out-of-Pocket Expense are combined.) [All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.] [Once the family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the [calendar year] [Contract Period].] [Member Copayments do not accumulate to the Out-of-Pocket Maximum.] [Deductible does not apply to the Maximum Out-of-Pocket Expense.]

Deleted:

Formatted: Font color: Black

[Maximum Policy Benefit per Member]	[None] [\$1,000,000-\$10,000,000] <u>[Unlimited]</u>	[None] [\$1,000,000-\$10,000,000] <u>[Unlimited]</u>
--	--	--

[(Plan pays a maximum benefit which is separate for In-Network and Out-of-Network.)]

{OR}

[Maximum Policy Benefit per Member]	[None] [\$1,000,000-\$10,000,000] <u>[Unlimited]</u>
--	--

[(Plan pays a maximum benefit which includes both In-Network and Out-of-Network.)]

[4th Quarter Deductible Carryover]	[Applicable] [Not Applicable]	[Applicable] [Not Applicable]
--	-------------------------------	-------------------------------

{OR}

UHC AR Heritage Plus Rev 08/12 [Insert Plan Code]

Deleted: Schedule of Benefits
Deleted: Rev1
Deleted: 2/12
Deleted: 0

Benefits for Covered Services	Participating Provider In-Network Member Pays	Non-Participating Provider (1) Out-of-Network Member Pays
Preventive Care Services <i>("Preventive Care" refers to examinations and services recommended by the U.S. Preventive Services Task Force or preventive care services mandated by state or federal law or regulation.)</i>		
Physical Exams/Well-Child Care	[[\$0 Copayment per visit] [Balance of Allowed Charge paid at 100%.] [[0% of Allowed Charge] [Deductible does not apply]] Covered at 100%.	[0%- 60 %] of Allowed Charge [after Deductible] [Deductible does not apply] [Not Covered]
Immunizations	Charge paid at 100% for children newborn through 18 years of age For members over the age of 18, [[\$0 Copayment per visit] [Balance of Allowed Charge paid at 100%.] [[0% of Allowed Charge] [Deductible does not apply]] Covered at 100%.	Charge paid at 100% for children newborn through 18 years of age. For members over the age of 18, [0%- 60 %] of Allowed Charge [after Deductible] [Deductible does not apply] [Not Covered].
Laboratory and X-ray	[[\$0 Copayment per visit] [Balance of Allowed Charge paid at 100%.] [[0% of Allowed Charge] [Deductible does not apply]] Covered at 100%.	[0%- 60 %] of Allowed Charge [after Deductible] [Deductible does not apply] [Not Covered]
Physician Office Services		
Office Visits	[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] Deductible does not apply if services received from a Primary Care Physician (PCP).	[0%- 60 %] of Allowed Charge [after Deductible] [Deductible does not apply.]
Office Surgery	[[\$0-\$500] Copayment per [visit] surgery] [[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] Deductible does not apply if services received from a Primary Care Physician (PCP).	[0%- 60 %] of Allowed Charge [after Deductible] [Deductible does not apply.]
Allergy Testing	[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] Deductible does not apply if services received from a Primary Care Physician (PCP).	[[0%- 60 %] of Allowed Charge [after Deductible] [Deductible does not apply.] [Not covered]
Allergy Injections	<i>For PCP/Specialist copay option, validate first with plan build</i> [[\$0-\$250] Copayment per injection] [[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [(if no office visit billed; otherwise only Office Visit [copayment] applies)] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] Deductible does not apply if services received from a Primary Care Physician (PCP).	[[0%- 60 %] of Allowed Charge [after Deductible] [Deductible does not apply.] [Not covered]
<div style="display: flex; justify-content: space-between;"> UHC AR Heritage Plus Rev 08/12 [Insert Plan Code] </div>		

- Deleted:** -\$75] [PCP][/] [~~\$5-\$100~~] [Specialist]
- Deleted:** -50%] of
- Deleted:** [after Deductible]
- Deleted:** -\$75] [PCP][/] [~~\$5-\$100~~] [Specialist]
- Deleted:** 5
- Deleted:** -50%]
- Deleted:** [after Deductible] [
- Deleted:** 5
- Deleted:** [for children newborn through 6 years of age.] [Services not covered for children age 7 years and up.]
- Deleted:** [[~~\$0-\$75~~] [PCP][/] [~~\$5-\$100~~] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
- Deleted:** , including diagnosis of infertility
- Deleted:** 5
- Deleted:** 5
- Deleted:** 5
- Deleted:** 100
- Deleted:** Schedule of Benefits
- Deleted:** Rev1
- Deleted:** 2/12
- Deleted:** 0

Benefits for Covered Services	Participating Provider In-Network Member Pays	Non-Participating Provider (1) Out-of-Network Member Pays	
Other Injections	<u>For PCP/Specialist copy option, validate first with plan build</u> [[0-\$250] Copayment per injection] [[0-\$75] [PCP]/] [\$5-\$100] [Specialist] Copayment per visit [(if no office visit billed; otherwise only Office Visit [copayment] applies)] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] <u>[Deductible does not apply if services received from a Primary Care Physician (PCP).]</u>	[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply.]	Deleted: 5 Deleted: 100
Maternity Physician Services	[[0-\$750] Copayment per pregnancy] [[0-\$75] [PCP]/] [\$5-\$100] [Specialist] Copayment per visit [Balance of Allowed Charge paid at 100%] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply.]	Deleted: 600 Deleted: 5
Newborn Physician Services Inpatient Outpatient	See "Physician Services at a Facility other than the Office" and "Facility Services." See "Physician Office Services."		
Physician Services at a Facility other than the Office			
Home Visits	[[0-\$75] [PCP]/] [\$5-\$100] [Specialist] Copayment per visit [Balance of Allowed Charge paid at 100%] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] <u>[Deductible does not apply if services received from a Primary Care Physician (PCP).]</u>	[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply]	Deleted: 5
Inpatient Facility Visits	[[0-\$75] [PCP]/] [\$5-\$100] [Specialist] Copayment per visit [Balance of Allowed Charge paid at 100%] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply]	Deleted: 5
Outpatient Facility Visits	[[0-\$75] [PCP]/] [\$5-\$100] [Specialist] Copayment per visit [Balance of Allowed Charge paid at 100%] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply]	Deleted: 5
Inpatient Surgery	[[0-\$1,000] Copayment per surgery] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply]	Deleted: 5
Outpatient Surgery	[[0-\$1,000] Copayment per surgery] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-60%] of Allowed Charge [after Deductible] [Deductible does not apply]	Deleted: 5
[Morbid Obesity Surgery (2)] [Any combination of In-Network and Out-of-Network Benefits are limited to a \$[50,000 – 250,000] maximum policy benefit per member.]	[See "Physician Office Services," "Physician Services at a Facility other than the Office," and "Facility Services."]		Deleted: Schedule of Benefits Deleted: Rev1 Deleted: 2/12 Deleted: 0

Benefits for Covered Services	Participating Provider In-Network Member Pays	Non-Participating Provider (1) Out-of-Network Member Pays
-------------------------------	---	---

Emergency Services

[(Follow-up care obtained in the emergency room is not covered.)]

Emergency Room Physician	[[\$0-\$1000] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	Covered the same as In-Network Services [[\$0-\$1000] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]
Emergency Room	[[\$0-\$1000] Copayment per visit for a Medical Emergency.] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge for a Medical Emergency] [after Deductible] [Deductible does not apply] [Emergency Room Copayment waived if admitted.] [Physician's services or other services separately charged may require a separate Copayment and/or Coinsurance in addition to any applicable Deductible, beyond the emergency room facility charge.] [Services must be obtained from a Participating Provider.]	Covered the same as In-Network Services [[\$0-\$1000] Copayment per visit for a Medical Emergency.] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge for a Medical Emergency] [after Deductible] [Deductible does not apply] [Emergency Room Copayment waived if admitted.] [Physician's services or other services separately charged may require a separate Copayment and/or Coinsurance in addition to any applicable Deductible, beyond the emergency room facility charge.] [Services must be obtained from a Participating Provider.]

Deleted: 500
Deleted: 500

Urgent Care Facility	[[\$0-\$1000] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply.]
-----------------------------	--	---

Deleted: 250
Deleted: 5

Ambulance Services	[[\$0-\$1000] Copayment] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [in a Medical Emergency] [after Deductible] [Deductible does not apply] [Non-emergency transports must be approved in advance by UnitedHealthcare.]	[[\$0-\$1000] Copayment] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [in a Medical Emergency] [after Deductible] [Deductible does not apply] [Non-emergency transports must be approved in advance by UnitedHealthcare.]
---------------------------	--	--

Deleted: 35
Deleted: 250
Deleted: 35
Deleted: 250

Laboratory and X-ray Services Outpatient	[[\$0-\$750] Copayment] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]
---	---	--

Deleted: 100
Deleted: 5

Office	[[\$0-\$750] Copayment] [[\$0-\$75] [PCP] / [\$5-\$100] [Specialist] Copayment] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Deductible does not apply if services received from a Primary Care Physician (PCP).]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]
---------------	--	--

Deleted: 100
Deleted: 5

<u>[Use for standard plans or standard contract variations only]</u> <u>[Major Diagnostics (MRI, MRA, CAT and PET Scans)]</u>	[[\$0-\$1000] Copayment] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply.]	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply.]
--	---	---

Deleted: Schedule of Benefits
Deleted: Rev1
Deleted: 2/12
Deleted: 0

[Use for variations only requesting separate locations]

[Major Diagnostics
(MRI, MRA, CAT and PET Scans)]

[Hospital (Outpatient)]

[[~~\$0-\$1000~~] Copayment] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply.]

[Office]

[[~~\$0-\$75~~] [PCP][/~~1~~] [~~\$5-\$100~~] [Specialist] [~~\$0-\$1000~~] Copayment][~~Copayment per visit~~] [Balance of Allowed Charge paid at 100%] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply.]

[Note X-ray and laboratory services separately charged by an independent laboratory may require separate Coinsurance and/or Deductible, beyond the physician's office Copayment, Coinsurance and/or Deductible.]

... [1]

Chemotherapy, Radiation Therapy, Renal Dialysis Services
Hospital (Outpatient)

[[~~\$0-\$750~~] Copayment] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]

Deleted: 100

Deleted: 5

Office

[[~~\$0-\$750~~] Copayment] [~~\$0-\$75~~] [PCP][/~~1~~] [~~\$5-\$100~~] [Specialist] Copayment [per visit]] [Balance of Allowed Charge paid at 100%] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]

Deleted: 100

Deleted: 5

Facility Services

Inpatient Facility [(2)]

[[~~\$0-\$1,500~~] Copayment per ~~surgery~~] [admission] [day] [up to a maximum of ~~2-5~~] continuous days] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]

Deleted: 0

Deleted: 5

Outpatient Facility

[[~~\$0-\$1,000~~] Copayment per [admission] day] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]

Deleted: 5

Skilled Nursing Facility [(2)] - *[(Limited to [40-180] Skilled Nursing Facility days per [calendar year] [Contract Period])] [(The In-Network and Out-of-Network days are combined.)] [Must be approved in advance by UnitedHealthcare]*

[[~~\$0-\$1,000~~] Copayment per [admission] [day] [up to a maximum of ~~2-5~~] continuous days] [Balance of Allowed Charge paid at ~~50-100~~%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]

Deleted: 5

Medical Equipment

[(Diabetic supplies do not count toward the [Durable Medical Equipment] [and] [Prosthetic Device] benefit maximum.)]

Deleted: 100

Deleted: 100

Deleted: 5

Deleted: Schedule of Benefits

Deleted: Rev1

Deleted: 2/12

Deleted: 0

Durable Medical Equipment [(2)]
[(Plan pays a maximum benefit of [\$2,500-\$40,000] per [calendar year] [Contract Period] for Durable Medical Equipment which includes both In-Network and Out-of-Network.)]

[[~~\$0-\$500~~] Copayment] [~~Balance of Allowed Charge paid at 100%~~] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]

[[~~\$0-\$500~~] Copayment] [~~then~~] [[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Not covered]

Prosthetic Devices (2) <i>[(Plan pays a maximum benefit of [\$2,500-\$40,000] per [calendar year] [Contract Period] for Prosthetic Devices which includes both In-Network and Out-of-Network.)]</i>	[[\$0-\$500] Copayment] [<u>Balance of Allowed Charge paid at 100%</u>] [<u>then</u>] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[\$0-\$500] Copayment] [<u>then</u>] [[0%- 60 %] of Allowed Charge] [after Deductible] [Deductible does not apply] [Not covered]	Deleted: 100 Deleted: 100 Deleted: 5
Hearing Aid Devices <i>[(Plan pays a maximum benefit of [\$2,500-\$5,000] per [calendar year] [Contract Period], but shall at least be \$1,400 per ear. Benefits are limited to a single purchase (including repair/replacement) every [year] [two-three] years.] [No Copayment, Coinsurance, or Deductible] will be applicable to Hearing Aid Coverage]</i>	[[\$0-\$500] Copayment] [<u>Balance of Allowed Charge paid at 100%</u>] [<u>then</u>] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply.]	[[\$0-\$500] Copayment] [<u>then</u>] [[0%- 60 %] of Allowed Charge] [after Deductible] [Deductible does not apply] [Not covered]	Deleted: 100 Deleted: 100 Deleted: 5
Foot Orthotics (2) <i>[(Limited to one pair custom molded shoe inserts once every [12] [24] months.)]</i>	[[\$0-\$500] Copayment] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[\$0-\$500] Copayment] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	Deleted: 1 Deleted: 1
Outpatient Rehabilitative Therapy <i>[(Limited to [60-120] visits per [calendar year] [Contract Period])] [(The In-Network and Out-of-Network visits are combined.)]</i>	<i>Use split copay for variations only, validate with plan build</i> [[\$0-\$75][PCP][/] [\$5-\$100][Specialist] [Balance of Allowed Charge paid at 100%.] [<u>then</u>] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[\$0-\$100] Copayment] [<u>then</u>][[0%- 60 %] of Allowed Charge] [after Deductible] [Deductible does not apply]	Deleted: 5
<i>Outpatient Rehabilitative Therapy includes physical, speech, and occupational therapy and cardiac (Phase I and II) and pulmonary rehabilitation.</i>			
<i>Bracketed language will be used for non-HDHP plans</i>			
[Spinal Manipulative Services]	[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [<u>then</u>] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[0%-50%] of Allowed Charge [after Deductible] [Deductible does not apply.]	
<i>Bracketed language will be used for HDHP plans</i>			
[Spinal Manipulative Services]	[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [<u>then</u>] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]]		
Home Health Services (2) <i>[(Limited to [60-120] visits per [calendar year] [Contract Period])] [(The In-Network and Out-of-Network visits are combined.)] [Must be approved in advance by UnitedHealthcare]</i>	[[\$0-\$500] Copayment] [<u>Balance of Allowed Charge paid at 100%</u>] [<u>then</u>] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[\$0-\$500] Copayment] [<u>then</u>] [[0%- 60 %] of Allowed Charge] [after Deductible] [Deductible does not apply] [Not covered]	Deleted: 100 Deleted: 1 Deleted: 5
Hospice Services (2)	[[\$5-\$500] Copayment per day] [Balance of Allowed Charge paid at 100%.] [<u>then</u>] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%- 60 %] of Allowed Charge] [after Deductible] [Deductible does not apply]	Deleted: 100 Deleted: 5
Respite Care (2) <i>[(Limited to [5-10] Respite Care days per [calendar year] [Contract Period])] [(The In-Network and Out-of-Network days are combined.)]</i>	[[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%- 60 %] of Allowed Charge] [after Deductible] [Deductible does not apply]	Deleted: 5 Deleted: Schedule of Benefits Deleted: Rev1 Deleted: 2/12 Deleted: 0

<p>Organ and Tissue Transplants [(2)]</p>	<p><u>[Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," and "Facility Services."]</u></p>	<p>[Not covered] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]</p>	<p>Deleted: Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," and "Facility Services."</p>
<p>[Cornea Transplants]</p>	<p>[Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," and "Facility Services."]</p>		
<p>[Mental Health Services] [Inpatient Facility] [(2)] <u>[[Limited to [10-100] days per [calendar year] [Contract Period]]</u> <u>[Benefits for any combination of Mental Health and Substance Abuse are limited as follows: Limited to [30-100] days per [calendar year] [Contract Period] for Inpatient Facility services.]]</u></p>	<p>[[\$0-\$1,500] Copayment per [admission] [day] [up to a maximum of [2-5] continuous days]] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] <u>[Covered the same as any other Inpatient Facility]</u></p>	<p>[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply] <u>[Covered the same as any other Inpatient Facility]</u></p>	<p>Deleted: 0 Deleted: 5</p>
<p>[Inpatient Physician Visits] [(2)] <u>[[Limited to [10-100] days per [calendar year] [Contract Period]]]</u></p>	<p>[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] <u>[Deductible does not apply if services received from a Primary Care Physician (PCP).] [Covered the same as any other Inpatient Physician Visit]</u></p>	<p>[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply] <u>[Covered the same as any other Inpatient Physician Visit]</u></p>	<p>Deleted: 1 Deleted: 5</p>
<p>[Outpatient Facility] [(2)] <u>[[Limited to [10-100] visits per [calendar year] [Contract Period]]</u> <u>[Benefits for any combination of Mental Health and Substance Abuse are limited as follows: Limited to [10-100] visits per [calendar year] [Contract Period] for Outpatient Facility services.]]</u></p>	<p>[[\$0-\$1,000] Copayment per [admission][day]] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] <u>[Covered the same as any other Outpatient Facility]</u></p>	<p>[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply] <u>[Covered the same as any other Outpatient Facility]</u></p>	<p>Deleted: 5 Deleted: per day</p>
<p>[Outpatient Physician Services] [(2)] <u>[[Limited to [10-100] visits per [calendar year] [Contract Period]]]</u></p>	<p>[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of Allowed Charge paid at 100%.] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] <u>[Deductible does not apply if services received from a Primary Care Physician (PCP).] [Covered the same as any other Outpatient Physician Service]</u></p>	<p>[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply] <u>[Covered the same as any other Outpatient Physician Service]</u></p>	<p>Deleted: 5</p>
<p>[Office Visits] [(2)] <u>[[Limited to [10-100] visits per [calendar year] [Contract Period]]]</u></p>	<p>[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [Balance of allowed charge paid at 100%][then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] <u>[Deductible does not apply if services received from a Primary Care Physician (PCP).] [Covered the same as any other Office Visit]</u></p>	<p>[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply] <u>[Covered the same as any other Office Visit]</u></p>	<p>Deleted: [Covered the same as any other Inpatient Physician Visit] Deleted: 5</p>
			<p>Deleted: Schedule of Benefits Deleted: Rev1 Deleted: 2/12 Deleted: 0</p>

[Autism Spectrum Disorders]

[Benefits for any inpatient and outpatient combination of *Autism Spectrum Disorder Services*, *for children under (18) years of age*, are limited as follows: [limited to \$50,000 in Eligible Expenses per year for covered *Autism Spectrum Disorder Services*]

[[~~\$0-\$1,500~~] Copayment per [admission] [day] [up to a maximum of ~~2-5~~] continuous days]] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [[~~\$0-\$1,000~~] Copayment per day] [Balance of Allowed Charge paid at 100%.] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]

[[~~0%-60%~~] of Allowed Charge] [after Deductible] [Deductible does not apply]

Deleted: 0
Deleted: 5

[Substance Abuse Services]

[Inpatient Facility] [(2)]
[[Limited to [10-100] days per [calendar year] [Contract Period]]
[Benefits for any combination of *Mental Health and Substance Abuse* are limited as follows: Limited to [30-100] days per [calendar year] [Contract Period] for *Inpatient Facility services*.]]

[[~~\$0-\$1,500~~] Copayment per [admission] [day] [up to a maximum of 5 continuous days]] [Balance of Allowed Charge paid at 100%.] [[then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other *Inpatient Facility*]

[[~~0%-60%~~] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other *Inpatient Facility*]

Deleted: 0
Deleted: 5

[Inpatient Physician Visits] [(2)]
[[Limited to [10-100] days per [calendar year] [Contract Period]]]

[[~~\$0-\$75~~] [PCP][/] [~~\$5-\$100~~] [Specialist] Copayment per visit] [Balance of allowed charge paid at 100%] [[then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Deductible does not apply if services received from a *Primary Care Physician (PCP)*.] [Covered the same as any other *Inpatient Physician Visit*]

[[~~0%-60%~~] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other *Inpatient Physician Visit*]

Deleted: 5
Deleted: [Inpatient Physician Visits] [(2)]

[Outpatient Facility] [(2)]
[[Limited to [10-100] visits per [calendar year] [Contract Period]]
[Benefits for any combination of *Mental Health and Substance Abuse* are limited as follows: Limited to [10-100] visits per [calendar year] [Contract Period] for *Outpatient Facility services*.]]

[[~~\$0-\$1,000~~] Copayment per [admission][day]] [Balance of allowed charge paid at 100%] [[then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other *Outpatient Facility*]

[[~~0%-60%~~] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other *Outpatient Facility*]

Deleted: 5
Deleted: visit]

[Outpatient Physician Services] [(2)]
[[Limited to [10-100] visits per [calendar year] [Contract Period]]]

[[~~\$0-\$75~~] [PCP][/] [~~\$5-\$100~~] [Specialist] Copayment per visit] [Balance of allowed charge paid at 100%] [[then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply] [Deductible does not apply if services received from a *Primary Care Physician (PCP)*.] [Covered the same as any other *Outpatient Physician service*]

[[~~0%-50%~~] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other *Outpatient Physician service*]

Deleted: [Outpatient Facility] [(2)]
Deleted: [Outpatient Physician Services] [(2)]

[Office Visits] [(2)]
[[Limited to [10-100] visits per [calendar year] [Contract Period]]]

[[~~\$0-\$75~~] [PCP][/] [~~\$5-\$100~~] [Specialist] Copayment per visit] [[0%-50%] of Allowed Charge] [after Deductible] [Balance of allowed charge paid at 100%] [Deductible does not apply] [Deductible does not apply if services received from a *Primary Care Physician (PCP)*.] [Covered the same as any other *Office Visit*]

[[~~0%-50%~~] of Allowed Charge] [after Deductible] [Deductible does not apply] [Covered the same as any other *Office Visit*]

Deleted: [Covered the same as any other *Inpatient Physician Visit*]
Deleted: [Office Visits] [(2)]

Deleted: [Covered the same as any other *Inpatient Physician Visit*]
Deleted: Schedule of Benefits
Deleted: Rev1
Deleted: 2/12
Deleted: 0

In vitro fertilization [(2)]	[[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Deductible does not apply]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]	Deleted: 5
[Any combination of In-Network and Out-of-Network Benefits are limited to a \$[15,000 – 50,000] maximum per Member per lifetime.]			Deleted:]
Medical Foods [(2)]	[[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Balance of allowed charge paid at 100%] [Deductible does not apply] [Covered the same as any other Office Visit]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]	Deleted: 5
[Musculoskeletal Disorders of the Face, Neck or Head [(2)]	[[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Balance of allowed charge paid at 100%] [Deductible does not apply] [Covered the same as any other Office Visit]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]	Deleted: 5
Orthotic Devices and Services [(2)]	[[[\$0-\$75] [PCP][/] [\$5-\$100] [Specialist] Copayment per visit] [then] [[0%-50%] of Allowed Charge] [after Deductible] [Balance of allowed charge paid at 100%] [Deductible does not apply] [Covered the same as any other Office Visit]	[[0%-60%] of Allowed Charge] [after Deductible] [Deductible does not apply]	Deleted: 5

Coverage Limitations

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

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

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

Definitions

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

- Deleted: Schedule of Benefits
- Deleted: Rev1
- Deleted: 2/12
- Deleted: 0

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

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

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

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

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

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

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

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

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

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

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

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

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

Exclusions

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

Deleted: Schedule of Benefits

Deleted: Rev1

Deleted: 2/12

Deleted: 0

